*the* **JOURNAL** *of* **SOCIAL THERAPY**

**Official Publication of the Medical Correctional Association**

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*first quarter 1960* *vol. 6, no. 1*

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## THE JOURNAL OF SOCIAL THERAPY

*disseminates information on the genesis, nature and treatment of aggressive behavior. It aims to encourage enlightenment through wider employment of the scientific approach. The benefits that can be drawn from this growing body of knowledge spring from its practical application with these objects: To reduce behavior that is destructive to the individual; and to minimize the costly and demoralizing impact upon society of all forms of deviant conduct.*

## JOINT MEETING

of

## MEDICAL CORRECTIONAL ASSOCIATION

with

## JAPANESE ASSOCIATION FOR CORRECTIONAL MEDICINE

## IN TOKYO — SEPTEMBER, 1960

THE members of the Medical Correctional Association, at the last annual meeting in Miami Beach, accepted an invitation extended by Masao Otsu, M.D., President of the Japanese Association for Correctional Medicine and Chief of the Medical and Classification Section, Correction Bureau, Ministry of Justice, to hold a joint meeting in Tokyo between September 15 and 20. The program will cover every aspect of correctional medicine and related problems, with panel discussions and translating facilities.

The two-day meeting will be followed by elected sightseeing trips or visits to institutions and incidental entertainment provided by the Japanese Committee of Arrangements.

Participants in the meeting plan to travel from Seattle to Tokyo by chartered plane and to return by way of Hawaii, where a two-day stopover is scheduled en route to San Francisco. Those who plan to attend the meeting will enjoy the same fare reduction as the members of the Congress. The approximate traveling expense is $650, not including land arrangements.

The event promises an exceptional opportunity for an exchange of scientific information, as well as a delightful experience.

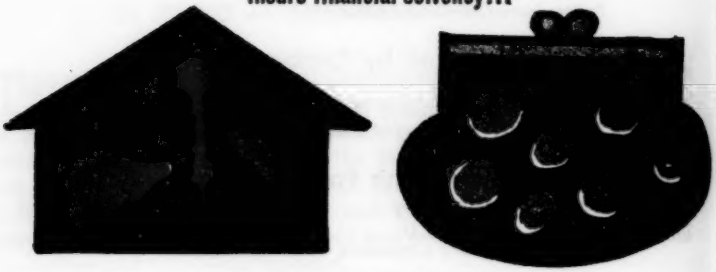
Registration and further information may be obtained from: Ralph S. Banay, M.D., Secretary-Treasurer, 927 Fifth Avenue, New York 21, N. Y.

## CONTENTS

First quarter 1960 (Volume 6 number 1)

# like money in the bank...

**just as savings—not pocket money—
insure financial solvency...**



**so iron reserves—not hemoglobin—
insure physiologic solvency**

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(1) Holly, R. G.: Postgrad. Med. 28:418, 1959. (2) Evans, L. A. J., in Wallerstein, R. O., and Mettler, S. R.: Iron in Clinical Medicine, Berkeley, Univ. California Press, 1958, p. 170. (3) Schwartz, L.; Greenwald, J. C., and Tendler, D.: Am. J. Obst. & Gynec. 75:829, 1958.

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# POINT OF VIEW

## THE CHESSMAN CASE AND ITS REPERCUSSIONS

WHEN Caryl Chessman entered death row at San Quentin in January, 1948, scheduled to die for a string of crimes that did not include murder, the murmur of public protest aroused by his sentence gave little indication of the crescendo of agitation and maneuver that would lead not only to his evading the death chamber for twelve years but also to the ballooning of his case into a *cause célèbre* of perhaps epochal significance. Among the factors responsible for this strange, protracted train of events, one is especially struck by the phenomenal personality of the man involved, the contemporaneous modification of public attitude toward the treatment of prisoners and the peculiar public and official ambivalence of the State of California on this question.

Here we have a startling constellation of anomalies: a condemned convict who by do-it-yourself legal sleight-of-hand kept the executioner at bay for twelve years and who in the same time published four sensational books despite the prison's efforts to prevent it; an accretion of public opinion in his behalf that swelled to a world-wide campaign; a dramatic last-minute eighth-time reprieve seemingly designed mainly to prevent the embarrassment of a traveling President, and the final distillation of these forces in a renewed crusade for the abolition of capital punishment.

An ironic aspect of the case is that, under a truly enlightened correctional philosophy, Chessman's sentence might have been mitigated in the first place on the ground of pathological defect. According to his own testimony, he suffered in childhood from encephalitis, which could have been the focus for his plainly psychopathic make-up. Among other trauma, he had seen his mother crippled in an accident and his father had twice attempted suicide in despair over his misfortunes. Antisocial monomanias like Chessman's are not produced spontaneously.

In the light of what the condemned man accomplished after maturing in prison, one must reflect again on the tragic social waste so often represented in the aberrance of talented people who stray into the destructive byways of crime. With an I.Q. of 136, a dynamic bent and other attributes that he demonstrated negatively, what might not he—and so many others like him—have accomplished if he had found therapeutic help at his crucial youthful turning-point?

Since 1948 public and offical enlightenment has come a long way on the question of correctional wisdom, and it is reasonable to assume that Chessman has been a beneficiary of this advancement. In his own egocentric way he has even contributed to it. By slow erosion the public is losing some of its appetite for recrimination and is beginning to perceive that there is room for a therapeutic approach to a large segment of the crime problem.

Implicit in the Chessman case is a sharp dichotomy in California, as elsewhere, between those who continue to cry for retributive justice and those who would give weight to ameliorating circumstances. Aside from emotions swayed by the repulsiveness of the crimes charged, there is plainly a large measure of conviction throughout the world that this man, by standing on the brink of death for twelve years, has suffered punishment enough and that execution of the long delayed death sentence at this stage would be a grotesque exaggeration of objectivity.

Whether Governor Brown's submission of the issue to the California Legislature will result in any amelioration of capital punishment now remains as the principal question left among the echoes of the Chessman case. In any event, ventilation of public opinion on the

question will at least demonstrate once again that there is a great and growing body of conviction that the taking of a life for a life is only another form of murder, even more repugnant and anachronistic than vengeful temporal punishment.

## AUTOMATISM AND CRIMINAL RESPONSIBILITY

We are becoming increasingly familiar with the fact that many violent episodes, including crimes by young people as well as adults, are carried out in a state of automatism attributable to pathological complications. In this moot entity in the annals of transgression we may recognize a manifestation of the grievous potentialities of insidious pathology. By reason of some organic defect, usually in combination with psychodynamic factors, it is possible for a sufferer to perpetrate an aggressive deed of which he might be incapable in his normal state, and of which he may have no conscious recollection after the event. As in other paroxysms, bizarre phenomena occur automatically, in what may be envisaged as a defense mechanism, when the distress caused by impaired functioning invokes a violent means of discharging tension and restoring a measure of equilibrium. Though automatism is not always demonstrably a form of epilepsy, it is recognizable as an equivalent, and the comparison helps one to understand some of the diverse symptomatology as a factor in delinquency and more serious crimes.

In many cases the pathological etiology can be confirmed by EEG findings and other examination, as well as by a history of injury or after-effects of disease or infection. In these extreme cases one is moved by regret that it had not been possible for the victim of a plainly pathological condition to obtain diagnosis and relief before his affliction reached its tragic denouement. Instead of this sort of futile, tardy hindsight, we are now in a position to marshal effective foresight to the end that children and others may be protected from the disastrous effects of undetected or neglected impairment.

It has been significantly noted that only some victims of brain injury develop convulsive syndromes. Even after allowing for the varied effects of the seat of injury and its grades of severity, some element of predisposition appears to play a part in the development of

automatic phenomena. It is evident that an insidious pathology that may cause aberrant behavior in one person can be borne by another without untoward incident. This leads to the concept that there are what have been called vulnerable families and their children who are especially susceptible to pathological influence.

There is hardly a phase or element of the process of growing up that does not contain a potentiality of harm. This truth connotes the overriding difficulty of effective social therapy, for the roots of delinquency are so complex that there is no constituent of the youthful organism and personality where one may not find them. We must look forward hopefully to a steadily approaching time when every such contingency will be systematically arrayed and vigilantly considered in our efforts to assure our children of an optimum hygiene.

How many potentially violent cases there are where, in the absence of sufficient stress or for other reasons, the climactic reaction has not been reached can only be imagined. This is a problem that gravely concerns society in general and presents an enormous challenge to the social aspects of medicine. The problem is to prevent the development of such pathology in the young and, aside from that, to forestall the emergence of more grievous behavior in those whose difficulty is detected before the condition is deeply fixed. It is a problem beyond the capacity of psychiatry alone, and the general practitioner does not ordinarily encounter or observe the full variety of these behavior manifestations. The American Academy of Pediatrics has launched a commendable campaign to alert pediatricians to the need for a truly complete health appraisal, embracing emotional and mental problems as well as physiological, structural and other aspects. This is an undertaking in which all the resources of medicine and its adjuvants should be enlisted.

The corollary problem, also unresolved, is the promulgation of workable criteria of responsibility in cases of organically determined aberrant behavior. In the purview of medicine the person who commits violence or any other crime in an automatism arising from organic defect is no more responsible than the epileptic is responsible for his convulsive seizure. Yet even when it can be shown clinically that the perpetrator of a violent crime was acting without conscious volition, a court is unlikely to accept a finding of irresponsibility.

Under the still controversial McNaghten Rule, such defendants are not legally insane and they must face the consequences of their misbehavior just as if they were presumably normal offenders. The light of reason is slowly dissolving this dilemma, but the force of inertia is still great and a complete solution is not yet available.

The over-all problem of social offense, organically based or otherwise, is too great to be reconciled by the medical and legal professions alone. It is a practical problem that requires a readjustment in the thinking of all society. When you encounter a communicable disease, society provides the means to cope with the risk. It should be society's responsibility also to establish other defense lines to put under proper treatment those whose physical or psychosocial condition presents a general risk. In this sense large segments of the crime problem are a public health problem, with socio-economic, emotional and public safety aspects: the person who for organic or functional reasons is a potential threat to public safety should be brought under control. On a long-term basis this may be achieved through proper vigilance in the schools to all aspects of the public health potential. Unless and until that is done, every effort needs to be made to find and help those whose condition is a public peril. We know that many who are aware of their difficulty are prevented by their ego from seeking or accepting the indicated therapy.

As for the legal responsibility of victims of insidious pathology, those who go on to climatic violence without having known of their affliction are in one category; those who commit organically determined crimes after they have been apprised of their defect should constitute quite another category.

## Psychiatric Aspects of Drug Addiction

THERE are said to be at least 60,000 narcotic addicts in the United States, although the number varies periodically and was placed as high as 150,000 in the middle Twenties. The problem of treatment and control is not so great quantitatively as those of mental illness, alcoholism and tuberculosis, but it presents unique difficulties. In its social aspects addiction impinges crucially upon the crime situation, on broad areas of psychopathology and on questions of social hygiene.

Since the core of the problem is the susceptibility of a particular individual to an insidious habit, it addresses its predominant challenge to the resources of psychiatry.

The Manhattan College Institute for Forensic Research, in cooperation with the Metropolitan Law Enforcement Conference, devoted one of its illuminating forums recently to the narcotics problem. From the broad survey of the various facets of the question there presented, a discussion of the personal application of the issue, as symbolized in a characteristic case, is offered here.

Doris, 30, married, with one child, had been addicted to Demerol for ten years. She was an only child, never much interested in school, with a bad record of cutting classes. She grew up to be an attractive girl who always wanted to be better dressed than her friends. Her mother was an invalid, crippled by arthritis for ten years and completely blind. She described her father as a handsome man. Though there was thirty-three years' age difference between them, when she walked with him people thought she was his wife. The father pampered her; she could buy whatever she wanted, a tacit return for her care of the mother. The mother resisted efforts to place her in a nursing home or a hospital and there was much bickering in the home.

The father-daughter relationship deteriorated when he took up with another woman who became his girl friend. From then on Doris went out nightly, stopping in a bar for drinks and to listen to the jukebox. A man there showed an interest in her and she became involved with him. A child was born out of wedlock and she complained that she had been pressured into giving up the child for adoption. While she was in the hospital she felt really comfortable for the first time, since everyone catered to her. An orthopedist became interested in her, took complete charge of her and they became engaged. He eventually settled in Carolina and she went there, but disliked it and went to Florida for a rest. On the plane she formed an attachment for a pilot and at length they were engaged. They returned to New York, but the pilot's glamour vanished and she went out on a blind date with a girl friend and thus met her husband. They were married after five days' acquaintance.

She soon learned that her husband was a gambler, more inter-

ested in that hazard than in sex relations. She told how his eyes lighted up when he saw a game, even on television, on which he had a bet. He was aping a brother, a thrice-married bookmaker well supplied with money, who treated his girl friend to fur coats and other pleasures and drove the latest cars.

Ten years ago, while returning from a night club with a boy friend, their car struck a stanchion and she was unconscious for several days. She enjoyed the second hospital experience because her worries were removed and she was cared for hand and foot. Because of her pain she was given Demerol and it gave her great relief. She befriended a man in the hospital who had a gall-bladder condition. She learned from him to imitate the pain and after leaving the hospital went from one doctor to another, simulating pain and obtaining prescriptions.

One day she found that she was pregnant again and took an overdose of the drug, as a result of which she landed in Lexington Hospital. As soon as she was discharged she returned to her addiction. A doctor from whom she obtained prescriptions became suspicious, called a druggist with whom she was acquainted and learned that she had forged prescriptions. This resulted in arrest.

It appears that long before the addiction started there were psychological and physical evidences that prepared the way for the onset of the habit. This narcissistic, self- indulgent, self-loving person fancied taking her mother's place at home and enjoyed the phantasy that people believed she was her father's wife. But when the father disappointed her by getting a girl friend, she began to live a reckless, uncontrolled, dissolute and irresponsible existence, switching her boy friends frequently without emotional reaction, driven by momentary impulses and phantasies, choosing only men she could rule and manipulate according to her fancy.

Her greatest complaint, even now, is that her husband never told her she was beautiful, but criticized her when she did not use make-up. She was most demanding and asked him for money incessantly, although he earned about $100 a week as manager of a supermarket. There was never enough money to satisfy her demands and the husband forged some checks and went to jail for six months. She complained that he was cold to her, that she had to be the ag-

gressor in sex relations and that she felt funny about approaching him for their sexual needs. At the time of her marriage she was comforted by a doctor's opinion that because of her accident she would not have children and she felt she could indulge in sexual life without responsibility. She promptly became pregnant and unsuccessfully tried to abort.

A person with such a chaotic, uprooted, irresponsible existence, with no standards or religion, clearly driven by the pleasure principle, is most likely to become subject to drug addiction. Treatment of this type of person cannot be withdrawal alone. Withdrawal would leave such a cavity in the personality structure, without support and reconstruction, that the person would eventually crumble, inevitably deteriorating to the road that leads to the mental hospital, prison or suicide.

## Medical Correctional Association Is Now Affiliated With American Association For Advancement of Science

THE Council of the American Association for the Advancement of Science, at its meeting last December 30, unanimously approved the affiliation of the Medical Correctional Association. The AAAS is the largest scientific society organized for a united endeavor to meet problems that concern the whole field of science. It aims to further the work of scientists and to facilitate cooperation among them; to improve the effectiveness of science in human welfare, and to promote public understanding.

The Medical Correctional Association is represented on the AAAS Council and its members will participate in the wide-ranging activities of the central organization. It is extremely gratifying to the MCA to reach this milestone and to receive this official recognition for its efforts to promote the philosophy and practice of a truly scientific approach to its endeavors.

# MURDER OF INFANTS BY PARENTS IN SITUATIONS OF STRESS

*Groves B. Smith, M.D.*

*Psychiatrist, Illinois Southern Penitentiary, Menard*

THE problems involved in a discussion of murder, manslaughter and the taking of life present considerable variation both in the manner in which we approach the problem and from the viewpoint of interpretation. In an extremely large number of cases, the *situational* as well as the *personality pattern* leading to conflict is of utmost importance in evaluating the *motivations* for such behavior. The six cases here represent an unusual segment in the evaluation of motivation.

We have ruled out of the present discussion the commission of crime by adolescents and by the older group of persons in whom senile changes and brain damage are factors. In the remaining group there may or may not be evidence that they knew the nature of the act for which they were charged or that they were in a position fully to understand the difference between right and wrong under the McNaghten Rule. The majority of even these cases, nevertheless, disclose evidence of *emotional instability* and *impairment* that would lead them into conflict with socially acceptable behavior.

Without question, there are many individuals in whom the commission of murder or manslaughter represents deviant thinking and whose actions are irresponsible. It is, therefore, right to accept the

legal recognition, where there is insanity, that there is release from responsibility. By reason of this *lack of insight and understanding* of what led a person to the commission of such act, whether done directly as a result of his own warped thinking or as a result of hallucinatory and delusional factors, we may point out that all of these groups represent an important facet of criminal behavior.

Following are *three cases*, each of whom disclosed similar patterns of motivation for the killing of a child.

CASE No. 1. A male, 23 years of age, coming from a background of Mexican immigrant parents, presented pictures of *hostile undercurrents* and rigid defense mechanisms dating back to feelings of parental rejection and emotional deprivation. The family constellation had been broken by divorce when the inmate was 10 and, at time of admission, he disclosed a withdrawn, isolated pattern of behavior, with some *flattening* of *affect,* immaturity, compensatory egocentricity and a *low frustration threshold* but (in spite of all of this) the initial factor was the threat that came through the anticipated loss of the emotional support which he felt he needed through the rejecting behavior of his wife. Over a period of time, this led to hostilities which eventually built up to the point of explosiveness. In this individual, a previous *pattern of aggression* had been noted. He had been placed on probation the year before for an assault with a deadly weapon.

He had just finished feeding his seven-week-old baby, had placed him on a couch in the living room, then he and a 2 year-old daughter watched television. The baby began to cry. Without warning, the inmate picked up the child, striking him. The child immediately quieted, but the coroner's inquest disclosed multiple bruises about the face and both sides of the head; also there was evidence that the baby's arm had been fractured in a similar explosive pattern of behavior some two weeks before.

When questioned, he explained: "I was supposed to have killed my seven-week old son. They said the baby got beaten up, that I hit him more than once." He said the baby had been left with the mother-in-law at the time the baby's arm was broken and that he did not know how this had come about. "I went out. When I returned, the baby wasn't breathing. I called my wife, who was staying with a girl friend.

I was frantic. The fire department pulmotor squad was unable to bring him to and he was taken to the hospital and pronounced dead."

At this point in the interview the motivating factors came to light; he stating: "When I got up in the morning, there was no one to watch the children. I let my wife run around because I don't want to go out. I want to stay at home. Nevertheless, for the past year, I have worried for fear that my wife will go out and she will not come back, for she has shown that she does not care for me as in the past."

CASE No. 2. A male of 20 years beat his twelve-month old son to the extent that the child died. He and his wife attempted to revive the child by breathing into its mouth. The beating happened at 9 p.m. Some three hours later, they gave up attempting to revive the child and, about 3:30 a.m., accepted the fact that the child was dead. They did not call a doctor for the reason that he would discover the beating, nor did they have a funeral. He and his wife went to a nearby farm, dug a grave and buried the child.

In his confession, the inmate admitted beating the child on two other occasions "because he wouldn't mind." The parents, when interrogated, indicated that "a Welfare woman had picked up" the child and taken him away. This story was not believed, leading to an investigation. The father was sentenced to a term of eight to fourteen years and the wife was sentenced as an accessory to the crime.

The background material shows that he had progressed to the seventh grade in school, had been a farmer, had been married since 1957 and that there had been no record of previous antisocial behavior. In an attempt to rationalize his behavior, he said he had been hurt in an automobile wreck some years before and that "the doctor told me never to get excited, that something awful might happen."

Underlying this, however we have an individual in whom there had been conflicts in the marriage. He was extremely jealous of his wife, refused to visit with his brothers or sisters, stating that his wife did not want him to. There had been a major change in attitude and philosophy. Sometimes he would refuse to talk to members of his family. Undoubtedly some of this came as a result of his unwillingness to accept the domination of his wife in doing what she wanted him to do.

On intelligence testing, he rated as low-average, with an AGCT

score of 84. His personality change had not prevented his acceptance by the community as an average citizen and his neighbors had no idea of mental illness or mental disease. It is signifcant, however, that a description by other members of the family indicated he had always been looked upon as headstrong and has a "very bad temper," which undoubtedly laid the foundation for his aggressiveness.

CASE No. 3. A 27-year-old white male was admitted under a three to fourteen year sentence for voluntary manslaughter. The official statement indicated that the wife had left him to care for their three-month-old baby. The baby had colic and began to cry. Inmate admitted picking up the baby, squeezing the child until it caused death. At the time of his arrest, and at the time of admission, he admitted his guilt, although it is evident that he was unable to accept responsibility for the act. He rationalized the fact that he had been drinking heavily and. undoubtedly, he had used alcohol as a means of retreat from facing the realities and problems of marriage. There is no record of previous arrests.

Inmate came from a family background in which the father had a disabling neurosis, was irritable, high-strung and nervous. The mother was always under tension. The economic status was comfortable, he having graduated from high school and entering an academy when 18. For some years after this he worked in a large industry, later joining the armed forces. After two years of service he received an honorable discharge.

He was overly proud, worrying about finances and "keeping up with the Joneses." However, he kept his feelings bottled up, building tensions out of all proportion to the seriousness of the situation. He became frustrated, both in industry and while in service, because he did not get the advancements he anticipated.

Upon admission to the penal system he felt insecure, knowing that he would be the object of ridicule and derision by others who could not tolerate a person who had killed his own child. He was of superior intelligence by Army Alpha studies.

Within three months, he became disturbed, disclosing evidence of an acute emotional break, becoming noisy, negativistic, hearing voices calling him names, and "I know that I have harmed people in my family. No one knows where my mother is. No one knows where

my sister is. They are supposed to be here. Even my wife has deserted me. I can hear them talking to me day and night." He was completely lacking in insight and judgment, the picture being clearly that of an acute schizophrenic break with paranoid features precipitated by tremendous, deepseated guilt for his behavior.

He reacted definitely over a period of a year to acute hallucinatory mechanisms.

Following his admission, he completely ignored the fact that the baby was dead. He would write home wanting to know where the baby was. Following each visit, he became acutely agitated. Occasionally he refused to see his wife. However, there were times when he admitted to other inmates his part in killing the baby, so that it was clearly an amnesic event which he could not face when in contact with members of his family.

Following electro-shock therapy, there was clinical improvement. However, there still is a distortion in thinking. He became quite hostile toward the physician who administered the shock treatments. Over the year he became psychotic and confused; it becoming impossible for him to abide by rules and regulations and he was aggressive. During the past six months, there has been stabilization to the point where he now has been given work assignments. There still are periods when he becomes acutely depressed and indifferent to what is going on, refusing to associate with other inmates and tending to wander off to be by himself. The problem has been complicated by the question of divorce on the part of the wife. However, the inmate is not aware that such a proceeding is in the offing. Here we are dealing with an individual who, prior to the commission of this act, had never disclosed any mental impairment.

In each of these three cases we have a similar *motivation* of deepseated conflict which created tension; the tensions eventually building up to an explosive point, caused by the simple crying of a baby, and leading to aggressiveness and to the death of the infants. In two of the cases there has been a *frank break with reality brought about by the constant sense of guilt.* In the third case, although this was the one person who had disclosed personality changes, there was a complete denial in outward expression of what had happened.

OVER the last twenty-five years, I have had occasion to examine a large number of *female* patients in a general psychiatric practice, many of whom had been passing through an *acute anxiety state* and some sufficiently serious to warrant classification as a reactive depressive pattern. The onset of many of these cases occurred during the *menopause,* others during *postpartum* months, and in many cases presenting residuals of an active postpartum psychosis.

In all of these patients there was one predominating symptom, anxiety and fear that they would do harm to their child or children, out of all proportion to the severity of the presenting picture. This clearly represented the fear that was true in at least 95% of all of these mild depressive states. In many cases, these were stabilized by the use of shock therapy, tranquilizing medication, or through psychotherapy. Nevertheless, in the over-all picture of at least *1000* persons, it is surprising that there were only three cases in whom the problems led to the actual killing of the child.

The first case was a young woman of 30 who, following the birth of twins, passed through a depression. She had been looked upon by the family as an emotionally retarded, dependent person but she still was able to maintain the daily care of her household and to accept the responsibilities of life on a farm. Gradually the depression increased, she becoming more and more negligent in the daily care and welfare not only of feeding and personal cleanliness of the children but of herself and of her household. She disclosed periods of marked mental confusion characterized by agitated patterns in which she would put the children in their crib, walking off down the road by herself — to be discovered by others sitting by the roadside, taking off her shoes, staring off into space, apparently oblivious of those who passed.

At times she represented the picture of a mild *catatonic stupor* in an attitude of prayer. Upon returning from one of these episodes, the husband being absent from the home, she went in and killed both twins by striking each over the head with a piece of wood. When the husband returned she was found in the kitchen, calmly rocking in the middle of the room, completely out of contact with reality and unable to accept the fact that she had been guilty of the act of which she had been fearful for some weeks.

There is no question that this represented definite evidence of

mental disease. The behavior was clearly that of an irresponsible person, mentally ill, whose condition unfortunately had not been recognized by members of the family or by the community prior to the commission of the act.

THE second case, a Jewish woman, had progressed through high school and had disclosed *anxiety mechanisms* with occasional patterns of *schizoid thinking*. She later married but could not accept the problems of marriage. In spite of this, however, she continued to carry on in the home. The husband was attending school and she herself was attending classes until the birth of their third child. Four days after delivery, there was the development of a *postpartum psychosis*, characterized by delusions, hallucinations and feelings of inferiority that led to her being hospitalized and given electro-shock therapy. She was discharged as in partial remission, but refused to go back for further psychiatric help.

She returned to the family, wandering about the house, presenting the picture of an affect depression type of response, with blocking, and with self-depreciatory attitudes and philosophies.

The family, using poor judgment, allowed her to take a train trip to a distant city. While en route, her behavior was noted by a physician on the train, who recommended that she get off the train and go to a hospital. Over the next twenty-four hours she refused — getting on and off the train at each stop some eight or ten times, being distraught, depressed and agitated.

Shortly after reaching her destination, she attempted suicide on successive days by slashing her throat and by drinking caustic lye.

Over a period of the next six weeks she was under constant observation by members of the family and gradually there was a decrease in the degree of agitation. The family tired of the constant responsibility and she was permitted to continue the daily activities of the home. Nevertheless, the recurring patterns of self-depreciation, with ideas of reference, and with her "knowing" that she had no right to have been the mother of three children or to continue to have more children — these ideas were so commonplace that they were ignored.

On the day in question, the husband left early in the morning

for his classes. Upon his return, he was not greeted by the noise of the children. Investigation showed that his wife was sitting in the kitchen, completely out of touch with reality. Eventually he discovered that the children had been smothered to death by being placed in individual locked trunks.

Psychiatric examination clearly indicated we were dealing with a paranoid schizophrenia in which the underlying conflicts had been present for many years. There was an acute precipitation by a superimposed postpartum psychosis. There was no question that she was legally recognized as a person who was insane and not responsible for the act. She was later transferred to a state hospital, given extended shock therapy and insulin treatment and later being returned to the community — but still disclosing a schizophrenic acceptance of reality.

It is impossible to explain the willingness of husbands,, parents and the community to tolerate the degree of deviant behavior as demonstrated in both these cases. There were sufficient danger signals to have alerted any responsible psychiatrist as to the danger. Undoubtedly, much of this hazard stems from the fact, in one's daily practice, that one takes a calculated risk and it is only one in a hundred who finally breaks through and commits the fatal act.

THE *third case,* a person of entirely different temperamental type, was born and bred in a community of 4,000, had worked in various households as a domestic, eventually transferring her work to employment in a restaurant. In due course, she became involved with a number of young men and eventually became pregnant. Lacking friends, relatives or anyone to whom she could turn for guidance, she covered up the pregnancy, purchasing a corset, lacing it tight, and continuing with her daily work until the day of her delivery.

When seized with recurring pains, she retired to her boarding house. The baby came and was delivered by herself, she having the foresight to tie the cord; but, nevertheless, there was a tremendous loss of blood. Panicky, she managed to clean herself but, while the baby showed evidence of being a normal child, breathing, she could not face the realities of the situation.

She obtained a small box, put the baby in it, smothering the baby in the process, calmly took the baby out and got into a car, drove down a road and deposited the box at the roadside.

She returned to work at her regular shift, stating she had the flu and was feeling ill. She was eventually allowed to return to her room. In the meantime, a road maintenance worker came across the box, discovering the infant. Eventually the trail led to this girl, who had returned to work after an absence of forty-eight hours. When confronted with the evidence, she confessed.

In spite of this trauma, she did not break. She was in a position to give a connected story as to what had happened and of the circumstances. Here we were dealing with an *emotionally retarded* borderline *mentally retarded* girl who could not accept the disgrace of an illegitimate child and felt that she could "get away with covering things up." Here we are dealing with *ignorance,* lack of anyone to whom she might have turned — rather than mental disease per se.

In the three cases cited there is great contrast as one compares the motivations for the act. Two clearly were results of mental illness and the third a result of the problems of a lack of community acceptance. In none of the cases was there evidence of aggressiveness and in all there was a panicky desire to do what they felt was the right way to meet a situation they could not face.

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## Moral Conformity and the Crowd

AMERICAN society—and, more particularly, American democracy —has lived increasingly by comforming to whatever values appeared to be accepted by the élite or the majority of the moment. . . . What a man ought or ought not to do becomes determined not by objective laws immutable as the stars, but by the results of the latest public opinion poll. A man who gets into trouble because he is temporarily out of step with public opinion needs only to slow down or hurry up, as the case may be, to get back into line, and all will be right again with him and the world. Moral judgment becomes thus the matter of a daily plebiscite, and what is morally good becomes identical with what the crowd wants and tolerates.

—*Hans J. Morgenthau*

# SOCIAL PSYCHIATRY AND MENTAL HYGIENE IN THE EIGHTEENTH CENTURY

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DEVOTED representatives of the mental hygiene movement who believe that the psychopathological conditions of our age are the worst in the history of mankind are hopeful that they have found a helpful weapon for the prevention and cure of these conditions in what they call social psychiatry, which is the study of environmental causes of mental abnormality. We are told that study in this field is still very much in its beginnings, since the concept behind it is so new and revolutionary. It would appear, however, that there were some antecedents to our present-day social psychiatrists. The works of a number of writers on general health and mental hygiene in the first decades of the eighteenth to the beginning of the nineteenth century indicate that in the northern part of the British Isles there was, at the time, a well-developed social-psychiatric insight.

The first of these writers was George Cheyne (1671-1743), who was born near Aberdeen and who, after receiving his medical education under Pitcairn in Edinburgh, went to London, where he was caught up in the gay life of the British metropolis. The indulgent life did not fit well with his Scottish nature, and he developed a liver ailment and grew overweight. Taking stock of himself, he set out on a cure by means of a stringent diet of milk and vegetables. To this self-invented and self-tested diet he attributed the health, wealth and

fame of his later life. He established himself as a temperance doctor in London and at Bath, the famous spa frequented by the English nobility. He advocated diets consisting of vegetarian foods, meats naturally raised, that is, not coming from artificially fattened animals, and skim-milk. He wrote a number of books on health subjects which in his time were almost as popular as similar books published in France by the Swiss-French Simon André Tissot. Among his books was one published in 1733. *English Malady,* the title of which has survived as a curiosa in historical and cultural literature, but about the contents of which no one knows anything today.

The subtitle of *English Malady* suggests that it is a sort of psychiatric text; it reads: "A Treatise of Nervous Diseases of All Kinds, Spleens, Vapours, Lowness of Spirits, Hypochondriacal and Hysterical Distempers." In the preface we encounter what would today be considered the social-psychiatric approach:

> The moisture of our air, the variableness of our weather, the rankness and heaviness of our food, the wealth and abundance of the inhabitants, the inactivity and sedentary occupations of the better sort and the humour of living in great, populous and consequently unhealthy towns, have brought forth a class and set of distempers with atrocious and frightful symptoms, scarce known to our ancestors, and never raising to such fatal heights nor afflicting such numbers in any other known nation. These nervous disorders being computed to make almost one-third of the complaints of the people of condition in England.

Our belief that ours is the most "nervous" age meets impressive competition in Dr. Cheyne's view of mental illness and its social causes during his time.

CHEYNE'S social-psychiatric approach was, one might say, conditioned by the social atmosphere of his time. Family relations and professional difficulties are not primarily stressed. The point of view was rather what we might call a strongly naturalistic one in regard to the human environment. The environment causes advanced by Cheyne — for example, bad air and climate — would be the last to be considered today:

> If we add the present custom of living so much in great, populous, and over-grown cities; London — where nervous distempers

> are most frequent, outrageous and unnatural — is, so far as I know, the greatest, most capacious, close and populous city of the globe. The infinite number of fires, sulphurous and bituminous, the vast expanse of tallow and foetid oil in candles and lamps, under and above ground, the clouds of stinking breaths and perspiration, not to mention the ordure of so many diseased, both intelligent and unintelligent animals, the crowded churches, church-yards and burying-places, with putrefied bodies, the stinking butcherhouses, stables, dunghills, a.so., and the necessary stagnation, fermentation, and mixtures of such variety of all kinds are more than sufficient to putrefy, poison and infect the air for twenty miles round it. And which in time, must alter, weaken, destroy the healthiest constitutions of men and animals of all kinds; and accordingly it is in such-like cities, that these distempers are to be found in their highest and most astonishing symptoms; any lasting or solid cure is performed till the diseased be rusticated and purified from the infectious air and damps, transsubstantiated into their habits, by a great city, and till they have sucked in and incorporated the sweet, balmy, clear air of the country and driven the other out of their habit. For, by innumerable experiments it is certain, that nitre and acid of fresh, new air is as necessary towards life and health as fresh balmy food.

In the same way, Cheyne analyzed food, excesses and luxury of living, and other major factors of the social life of that age. As cure and prophylaxis, he recommended strict diet, exercise and controlled activities. At one point he recommended strict abstinence from animal foods and alcohol, concerning which he says: "If the patient stands this shock with firmness and patience he may be assured of success and his perfect recovery is at hand." This was probably the earliest advocated form of shock therapy, which, especially in our country, has had such a variety of successors.

ANOTHER social-psychiatric point of view was presented by Robert Whytt (1714-1766), who became President of the Royal College of Physicians of Edinburgh. Whytt was more a researcher, physiologist and neurologist than a practitioner and his scope is accordingly wider than Cheyne's. In 1764, using the spelling "Whyte" in his name, he published a psychiatric text, "Observations on the Nature, Causes and cure of those Diseases which have been commonly called Nervous, Hypochondriac or Hysteric." Although his preface sounds different from Cheyne's, basically the two men were animated by the same spirit:

> The disorders which are the subject of the following observations, have been treated under the names of flatulent, spasmodic, hypochondriac, or hysteric. Of late, they have also got the name of nervous; which application having been commonly given to many symptoms seemingly different, and very obscure in their nature, has often made it to be said, that physicians have bestowed the character of nervous on all those disorders whose nature and cause they were ignorant of. To wipe off this reproach, and at the same time to throw some light on nervous, hypochondriac and hysteric complaints, is the design of the following observations; which are also intended to show, how far the principles laid down in my essay on the vital and other involuntary motions of animals may be of use in explaining the nature of several diseases, and consequently, in leading to the most proper method of cure. Since, in almost every disease, the nerves suffer more or less, and there are very few disorders which may not in a large sense be called nervous, it might be thought that a treatise on nervous diseases should comprehend almost all the complaints to which the human body is liable.

In widening the scope of nervous suffering, however, Whytt did not look upon the outer world as the cause of such suffering, but rather on the totality of human nature itself.

> As many of these complaints depend upon the sympathy which obtains between the various parts of the body, it seems necessary to begin with some observations on the sympathy of the nerves; a subject of the greatest importance in pathology.

This leads to what one might call an internal social psychiatry, a primary study of the relationship of the nervous system to the other organs of the body and the way in which these organs and the nervous system are influenced by the outer world. Whytt here offers a first systematic somato-psychology and psychosomatology. As he himself explains it:

> If it should be said, that to account for diseases from the sensibility or sympathy of the nerves, while we know not wherein these powers consist, is no better than referring them to a *facultas incognita,* or to the hypothetical motions and countermotions of the animal spirits; I shall only answer, that although we cannot explain why grief or joy should by means of the nerves, excite a greater motion than usual, in the vessels of the lachrymal glands, yet it is leading us to the truth, and advancing one step farther in our knowl-

> edge. We see that the increased secretion of tears, occasioned by those passions of the mind, proceeds from this cause, and not from any compression of the lachrymal glands or their ducts, by the neighbouring muscles, as has been commonly imagined.

After distinguishing the borderline between general nervous pains and actual nervous and mental illness, Whytt proceeds to a study of the various forms of actual pathology. He develops a finely executed total and differential system of nervous impairments of the body, and finally, too, of their causes in the outer world. He refers to his predecessor George Cheyne, whom he evidently considers competent. In his presentation of the actual outer social sphere, Whytt follows Cheyne; what is new in his presentation, however, is the detailed working out of the inner effect of those outside causes and the almost phenomenological presentation of the dynamism of the nervous functions as such. By uniting the organic with the social aspect, Whytt brought knowledge of abnormal nervous function to the point of a total picture — something that had not been attempted before.

How much Whytt's aim was a view of the picture of human existence may be seen from quotations like the following from his book.

> A diminution of the moving power of the nerves, produces a debility of the whole body. A total want of this power, occasions either a partial or universal palsy, according as only a few of the nerves of the whole system is affected. When any of the muscles are deprived of the nervous influence, they are not only rendered paralytic, but soon after become smaller; because the circulation of the fluids cannot be carried on, as usual, through the very small vessels when they are deprived of the nervous power.

Certainly an amazing intuitive view of the reality of the function of the nerves!

TO THE historian, a further development of social-psychiatric thinking, that presented by the work of the Scottish physician Thomas Trotter (1760-1832), must appear a kind of synthesis. Trotter started his career as a medical orderly in the British Navy, but interrupted his twenty years of medical service on the seven seas to earn an M.D. He was a reformer at heart, and in his writings propagandized for the

development and improvement of medical services in the British Navy. After finally settling down on land at Newcastle, he became a fierce fighter against alcoholism. It is reported that he went after inns and distillery vats with an axe. In 1807 he capped his writings with a book having the unusually long title of "View of the Nervous Temperament, being a practical inquiry into the Increasing Prevalence, Prevention and Treatment of those Diseases commonly called Nervous, Bilious, Stomach, and Liver Complaints; Indigestion; Low Spirits, Gout, a.so."

Reading the dedication and introduction of this book, we cannot but recognize in Trotter the successor to Drs. Cheyne and Whytt, to whom he refers by name. He presents his thesis thus:

> Mankind have seldom been delighted with a picture of their infirmities and the physician who warns his fellow mortal how to evade them, is liable to be considered rather an officious adviser, than a welcome monitor. But if it is true, as I have said, that nervous diseases make up two-thirds of the whole with which civilized society is infected, and are tending fast to abridge the physical strength and mental capacities of the human race, it must be the duty of some person to sound the alarm and to announce the danger, however unprofitable the task.

No mental hygienist of our country has spoken with the vehemence of this nineteenth-century writer. But Trotter was more than an impulse fanatic:

> When I was a young man in the profession no disease puzzled me so much as those of the nervous kind. I was every day committing blunders: in vain I had recourse to books, for books could not supply the deficiency, and I was frequently mortified with seeing my patients get worse under my treatment. Time and much experience only, were capable of correcting my errors. What first gave my practice consistency, was the careful study of the nervous temperament; to mark what were its original pecularities; what its propensities; and by what causes its diseases were drawn forth.

And now there speaks a real predecessor of our modern mental hygienists:

> Much of my animadversions on these disorders, is with a view to the prevention; and if parents and guardians will only interest themselves in the business, my trouble cannot be in vain. It is indeed a task, in the present stage of society, that well deserves the attention

> of every friend of his fellow-creatures, and his country. Great Britain has outstripped rival states in her commercial greatness; let us therefore endeavour to preserve that ascendency which is so essential to our welfare in the convulsed condition of Europe, by the only means that can do it effectively. That is by recurring to simplicity of living and manners. So as to check the increasing prevalence of nervous disorders which if not restrained soon, must evidently sap our physical strength of constitution; make us an easy conquest to our invaders and ultimately convert us into a nation of slaves and idiots.

Nobody could speak more strongly in the cause of social-psychiatric therapy than did this English doctor a few pages later:

> In the present day, this class of diseases form by far the largest proportion of the whole, which come under the treatment of the physician. Sydenham, at the conclusion of the seventeenth century, computed fevers to constitute two-thirds of the diseases of mankind. But, at the beginning of the nineteenth century, we do not hesitate to affirm, that nervous disorders have now taken the place of fevers, and may be justly reckoned two-thirds of the whole, with which civilized society is afflicted. Dr. Cheyne, who wrote about the year 1733, in his work entitled the *English Malady*, makes nervous disorders almost one-third of the complaints of people of condition in England, from which we are led to believe they were then little known among the inferior orders. But from causes, to be hereafter investigated, we shall find that nervous ailments are no longer confined to the better ranks in life, but rapidly extending to the poorer classes. In this neighborhood, as far as I am able to judge from my own experience, they are by no means limited to the rich.

We find here a most realistic and practical basis for a social-psychiatric approach, namely, an open eye for social conditions. Unlike the socialite Dr. Cheyne, Dr. Trotter saw not only the British nobility but also the common man as afflicted with mental and emotional troubles. From this point of view, he arrives at a social aspect of the causes of mental ailments.

He first points, in the manner of Cheyne, to general conditions in England:

> It is the peculiar situation of Britain; insular variations of climate and atmosphere; its political institutions and free government and above all its vast wealth, so diffused among all ranks of people.

But then he becomes more concrete and enumerates ten "remote causes

of nervous diseases": "Air, Exercise, Food, Clothing, Passions of the Mind, Intense Study, Lactation, Miscarriage and Premature Labour, Climate, and Medicine." Although modern sociologists could construct a more detailed inventory of possible causes of mental disturbances in presentday life, Trotter's wide scope and clearer insight into major factors of nervous disease at the start of the nineteenth century cannot but be considered astonishing. There are several factors, such as air, food, clothing and climate, which, as Trotter himself pointed out, had already been recognized as causative, especially by Cheyne; the acknowledgment of passion as a cause of mental disturbance goes back to ancient times. But for his time Dr. Trotter's presentation was certainly novel.

MODERN psychological geneticism of the analytical type may greet Dr. Trotter as a predecessor of their concept of childhood causes of mental abnormality and neuroses. Besides the dangers of unfortunate birth, Trotter considers lactation an important element affecting mental health, and one which he saw as valid for both infant and mother.

Of special significance is Trotter's emphasis on the dangers of medication to mental health:

> All nervous persons are uncommonly fond of drugs; and they are the chief consumers of advertised remedies, which they conceal from their medical friends. Among some well-meaning people this inordinate desire for medicine has frequently become of itself a disease.

He follows up this explanation with a forty-page description of the most common medicines of his time, pointing out in what respect they may prove to be dangerous to the mental health of the patient.

There is another fascinating aspect of Trotter's social psychiatry, one that is easy to understand when one considers that he viewed the entire population in its involvement with mental ills. It is at the same time an aspect about which we at present lack satisfactory insight. It concerns the differentiation of social groups with respect to abnormal behavior. Indeed, no one who did not have a good eye for the entire social aspect could be aware of the specific mental abnormalities which can occur among specific social groups: "Literary Men, Men of Business, the Idle and the Dissipated, the Artificer and Manu-

facturer, Those Employed in Drudgery, Persons Returning from the Colonies, and last not least, The Female Sex; consisting of the higher, middle and lower Orders of Women." In short, detailed chapters on each of these groups, Trotter shows "how business, customs and manners influence health." This is surely social psychiatry in a most specific form, if any can be acknowledged.

Trotter and his British predecessors were not alone in believeing that their own country harbored the most nervous ills. During Whytt's time there was the French-Swiss medical writer of his time on the Continent, who wrote, in an eloquent and brilliant style, little health books which, with the same social approach as Trotter, he addressed to various social groups. There was one addressed to "Men of Letters," one to "Men of the World" and one especially for "The Ladies" on the ways of life at the time of the French kings. One, which became internationally famous, was addressed to "Youth." Tissot thundered at the youth of his day " that it was about to become dangerously decadent, addicted to the mass neurosis of onanism by which they endangered the mankind to perish." Later in life he wrote, in the style of Trotter, a large book, *The Nerves and Their Maladies,* in the introduction to which he joined the chorus of his British colleagues: "Nervous diseases have increased in manifold, meanwhile others were on the decrease." Nervous ailments, especially in urban communities, he said, were the most common illnesses of the time.

As the present writer pointed out some time ago, Tissot had extraordinary insight into sexual regression, which Freud a hundred years later made the central idea of his psychoanalysis. Now we cannot but acknowledge that these Scottish doctors of the eighteenth and early nineteenth century provided a preview of what today we try to present as a major new achievement of our time — mental hygiene and social psychiatry.

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We hardly find any persons of good sense save those who agree with us.——*LaRochefoucauld*

# HOMOSEXUALITY TREATED BY COMBINED PSYCHOTHERAPY

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THIS is a presentation of one instance of the combined use of individual and group psychotherapy in the treatment of homosexuality. The author uses the combined method as the treatment of choice for psychoneurotic conditions in general. It shares the advantage of individual treatment, in which privacy and trust permit the sharing of very personal feelings and careful individual attention. It also shares the advantage of group therapy in that the therapist sees the patient interacting with several others and can interpret this behavior to the patient either on the spot or, in more detail, in a subsequent individual session.

Considered in Hullian learning theory terms, a patient is fixated at a homosexual stage because there, for him, the excess of approach gradient (or attraction) over avoidance gradient (or anxiety) is at a minimum. One part of treatment must consist in decreasing the anxiety attached to mature genital relations. Here the Oedipal dynamics described by Freud are relevant. Treatment by interpretation, insight and working-through is traditionally done individually, but group can be a valuable adjunct, especially when a group of patients, such as homosexuals, have much in common.

It is important to decrease the attraction to homosexuality. Bergler's clinical work in this field has indicated that the chief gratification derived from the homosexual act is the masochistic pleasure in bitterness, feeling sorry for oneself and collecting injustices. Labeling leading to insight can sharply decrease this neurotic attraction. It can be especially effective in a group, in which patients can label each other's dynamics which they have in common.

A third aspect of treatment is the building up of an ego ideal that firmly rejects homosexuality. The therapist's expressed disappointment at neurotic behavior and approval of resistence to temptation can be very effective. Even more effective is a group norm, arrived at by the patients themselves together. But what is to prevent a group norm from being formed in favor of homosexuality? The individual relationship of patient to therapist can be used to keep the group standard oriented to fostering recovery rather than neurosis.

Now let us get down to cases. A group was formed of three homosexual men. All of them had been in individual treatment for some time before the group began: One for eighteen months, one for three months and one for six weeks.

Mr. I. was a 40-year-old divorced Jewish businessman. As a child, he feared and hated his father, who was always telling him he was effeminate, and he denied any resentment of his self-effacing overprotective mother. As an adult, he was fascinated by penises and kept having once-only sex contacts with men who were strangers to him. As a college student, he got two women pregnant to prove his masculinity. In later years, he continued to date like a college boy. He had a series of prolonged affairs with women, who would pursue him until finally, when they completely abased themselves, he would lose interest. He was briefly married to a fat women to whom he was not sexually attracted. He had many superficial male friendships on a "hail fellow well met" basis and was elected an officer in a civic club. His way of life revealed a compulsive and narcissistic character. He kept every minute of his time tightly scheduled to avoid wasting time and he systematically practiced exercises a certain number of hours a week to preserve the perfection of his body. Each episode of homosexuality was followed by a period of depression and low self-esteem lasting several days. After a few months of individual treatment

the homosexual behavior stopped, but he continued to masturbate (sometimes with homosexual thoughts) and to feel just as guilty afterward as after homosexuality. Interpretations were made about the self-punishing nature of his sexual behavior, and also of his general risk-taking, as exemplified by his somewhat reckless driving.

Mr. B. 26, was a married Protestant advertising writer, married with one child. He had had three months' individual treatment before the group began. Alone among the three, he had effeminate mannerisms and might have been spotted by a stranger as a homosexual. His father was strict and stern; his mother was bossy and overprotective and had frightened him with severe threats about sex. He had married hoping to appear mature and become "normal," but continued to have occasional once-only homosexual contacts with strangers. At the time he began treatment he complained of confusion, inability to concentrate, feeling overwhelmed by his troubles, irritability at noises, and financial worries. His work was impaired and every day he would phone the therapist to ask if he should go to work. The therapist assessed the picture as hysterical and kept interpreting to the patient his repression and unconscious dramatizing of his helplessness, pointing out that helplessness was not objectively necessary, but only resulted from the conversion symptoms. He, too, said that his homosexual behavior was always followed by remorse and distress, but that was difficult to check as no homosexual behavior occurred after treatment began.

The third member of the group, who had had only six individual sessions before group began, was the Rev. Mr. P., 29, a Protestant minister, married with four children. He came because of a situational upset and was not at all sure that he wanted to change his homosexuality. His chief defenses were repression and intellectualization. In treatment he talked suavely about many things and avoided mentioning the homosexuality as much as possible.

LET us pause to consider these three men as possible cases of masochism, as Bergler has suggested. Self-punishment or masochism may take several forms. Freud distinguished three, and others may be added. One (masochism by its original definition) is the physical perversion, which none of these men showed. A second form is dependent or oral masochism, in which the self-punishment consists of

acting in such a way as to be disappointed or let down in one's dependent needs, leaving one feeling bitter and deprived. By reinterpretation, this is a prominent feature of the form that Freud called "feminine masochism." B. showed this type most strikingly, though, after extended treatment, some of it could be discerned in I. also. (I.'s reaction formation against dependency tended to conceal this feature). A third type of masochism is one in which a person will repeatedly do things that his conscience will then punish him for, with feelings of remorse, self-blame and depression. I. showed this behavior pattern repeatedly during treatment, and B. told of its happening earlier. P. alone had no remorse (or at least no conscious remorse) for his homosexual behavior, and perhaps that was a bad prognostic sign. His self-punishment consisted of occasionally getting himself in trouble with authorities—a pattern that may be called masochistic in an extended sense. (It is doubtful that anything would be gained by extending the term masochism to include all self-defeating and hence all neurotic behavior.) Perhaps in this general category is I.'s risk-taking behavior; he took risks in his business and in his driving and it was easy to see that in his homosexuality he was also taking risks.

Now let us see what happened in the combined treatment. All three members of the group came unwilling, and only because the therapist had strongly recommended it. At the first meeting all seemed ill at ease. They did not introduce themselves by name. I. talked freely first. He said he was nervous over the group. He had awakened in the night with knots in his stomach. He told of his homosexuality, of his previous marriage and of his fear to marry again. P. intellectualized a little. He smiled and seemed at ease. He said he had a happy marriage in spite of his homosexuality. I. and B. were especially amazed to hear that P. had told his wife about his homosexuality. P. said it was part of his moral principles that a man should tell his wife about things like that. He neglected to add that he had not told his wife the full story about his homosexuality, for fear that she evidently thought it was all in the past. B. was fearful and hardly spoke at all. He kept staring at the floor in misery. For the first thirty minutes he did not even glance at the two other men.

At the second session only B. and I. were present. With emotion,

B. announced that, inspired by P., he had told his wife about his homosexuality after hinting to her about it for a day or two. He trembled in anticipation and was in tears when he told her, but she took it calmly (He commented that he had underestimated her.) He told the story with great feeling. I. listened in awe and asked questions about it. In answer to B.'s question, the therapist agreed that B. had done the right thing. B. on learning that I. had been in treatment a year and a half, wondered, is treatment any good? I. answered yes: "I've never had a happy day in my life until the last seven or eight months I've been coming here." He thought the absent P. was still a practicing homosexual and didn't intend to change.

He turned out to be right. P. dropped out of the group and never came back. The group continued with only two, though they still remembered P. and often spoke of him.

For a time B. continued to be discouraged and to feel sorry for himself. Once, individually, he told of his fascination with the story of Peter Pan, who never grew up. The therapist interpreted that B. wanted to avoid responsibility and to avoid sex. In group, the two patients joined in doubting the value of group therapy. The therapist commented wryly that one advantage of it was that they could gang up on the therapist.

WHAT the two men seemed to have in common was a feeling of bitterness, and the therapist kept interpreting the bitter feelings that both of them showed. In the group, B. expressed disapproval of I.'s sexual affairs with women to whom he was not married. Privately B. talked of resenting the group. He said he was not interested in I. He was frightened by an interpretive remark the therapist made about the vagina dentata fantasy. I., privately, said he was depressed when B. talked of suicide, even though he reassured B. and thereby himself. He also resented B.'s self-pity and felt like saying: "What right do you have to feel sorry for yourself? You have all the advantages I don't have — a wife and children. I'm the one who has a right to feel sorry for myself!" He would not say these things to B's face.

In group, I. reluctantly admitted that B. impressed him as an obvious homosexual who could be spotted by anyone. This horrified B. They exchanged their feelings about homosexuality; fascination and remorse; a dread of being found out. They discussed whether they

should blame their parents and whether they should feel they were mistreated in life, having been made homosexual (either by heredity or by early experience) without asking for it.

After the therapy group had been going about six weeks. B. rather suddenly lost his brooding depression and began to feel good. The change was obviously due to repression rather than to any marked progress in resolution of his problems. Later, he broke the repression barrier and began talking about his demanding wife. It was then that he made a significant discovery — that it was when he was feeling bitter and angry at his wife that he had the urge to do homosexual acts—a spiteful, revengeful urge.

Quite independently, I. and the therapist discovered something very much like that about I. His homosexual temptations (or his masturbations) occurred at times when he was feeling bitter and sorry for himself, especially when a woman had rejected his advances. Exchange of these experiences in group therapy reinforced the insight into this powerful neurotic impulse. Both patients read Bergler's book and applied it to themselves.

The two men exchanged stories on their temptations and strengthened and encouraged each other to resist temptation.

ANOTHER point they discovered they had in common was that both had sexual fantasies about their mothers and sisters, which they discussed in group as well as individually, trying to understand their anxiety which prevented them from having fully satisfactory relations with women. They discovered that they were both fearfully embarrassed at the thought of their mothers' knowing anything about their sexuality. Both had mothers who had been submissive to the father and were overprotective of the patients.

Their initial dislike for each other gradually gave way to mutual respect. It was not until they had been in group therapy together for eight months that they (somewhat pressed by the therapist) were willing to tell their last names. I. stopped resenting B., as B. no longer seemed effeminate; this change in B. was noted by the therapist, too: the feminine mannerisms had disappeared. I. accepted B. more, too, when he found that B's occupation was on a higher level than I. had credited him with. He came to admire B. for being honest and felt that he himself was not so honest.

The men began to do a good job of interpreting each other's behavior. B. gave a good dynamic interpretation of I.'s repetitive pattern with his girl friends and asked if that were what he would like to do to his mother. He continued to be shocked at I.'s whoring.

After a year, the therapist and both patients felt that maximum benefit had been reached and decided to discontinue individual and group therapy for B. and to continue I. for a while individually.

The therapist saw the results as follows: B. had regained his self-esteem on a basis that was not entirely due to repression. Previously failing in his work, he was now working well and had been promoted. He was no longer experiencing homosexual temptations and was having satisfactory sexual relations with his wife. B. felt confident that he would not return to homosexual behavior and the therapist agreed with him. The results with I. were less dramatic, but nonetheless solid. He had lost his anxiety and tension and had gained self-esteem. He had refrained from homosexual behavior for two years, something that he had never before been able to do, and was experiencing more and more sexual satisfaction in his relations with women. His affairs with women continued to have a neurotic pattern and he had not succeeded in achieving marriage. These were some of the reasons for continuing treatment.

Now, what may be concluded from this account of treatment? The two men who stuck with treatment seemed to benefit markedly, though neither could be regarded as completely cured of his psychoneurosis. It seems fair to say that this was a moderately successful treatment.

Is combined treatment necessary? Let us compare the combined psychotherapy with each of its separate components.

Would group therapy alone have done the job? This therapist does not feel that he has adequate understanding of his patients, rapport with them, or control of the course of treatment, with group therapy alone. The force of united group attitude can be a powerful one, either for or against treatment. The individual sessions not only brought out deeper and more personal material, but also gave rapport so that the therapist could guide the group in a direction to foster recovery rather than to foster homosexuality.

What about individual treatment alone? Would the same num-

ber of hours spent individually have done more good? This therapist thinks not. The combined treatment had some specific effects: 1. The discovery of neurotic problems in common behind the homosexual behavior of both brought them face to face with their neurotic motivations in a dramatic and convincing way that could not have occurred separately. 2. Learning to talk about their homosexual problems "in public" helped to extinguish their irrational fears about homosexuality and made it possible to lay the groundwork for more effective methods of control. 3. They reinforced each other's insight into the Oedipal fears that had prevented heterosexual enjoyment, and thereby helped to extinguish these anxieties, making possible more enjoyment of mature heterosexuality. 4. By forming a "reference group" they established a "public opinion" by which they gave each other emotional support and encouragement in staying away from homosexuality. This group climate of opinion was more effective than the therapist's attitude alone could have been in building an effective ego ideal in each of the patients.

This method has its limitations, which you no doubt have observed. One patient dropped out and the two others, while able to abandon their homosexual behavior, were only partly cured of their underlying psychoneuroses. Still, we have learned enough to suggest that the combined use of individual and group psychotherapy shows promise in the treatment of homosexuality and warrants further trial.

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THE ONE THING that the punishment of criminals does and does satisfactorily, although very expensively, is to gratify our passion for revenge.

*—Karl Menninger*

# DELUSIONS OF SCHIZOPHRENIC PATIENTS IN GROUP PSYCHOTHERAPY

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*and*

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It has been stated by various writers, such as G. Bychowski, R. and T. Lidz, and only recently by T. Freeman, John L. Cameron and Andrew McGhie, that group psychotherapy offers both in the short and in the long run great difficulties for schizophrenic patients who do not know how to interact with one another. The last three writers mentioned stated in a recent monograph that they had come to the conclusion that there was no evidence of group formation and that the patients were still behaving as isolated individuals. Nothing seemed to appear at all reminiscent of the phenomena to be found in the group of psychoneurotic patients, whether from the psychoanalytical point of view as found in S. R. Slavson, or from the point of view of other schools. The usual tendencies of other therapeutic groups, namely to express themes and aims and shared by all members, never seemed to occur among the schizophrenic patients, and this precluded the emergence of common aims and ideas as well as of differing opinions. Sometimes it was possible that the patients as a group were attempting to push forward some specific problem, but neither the individual members nor often the therapists were able to grasp it. Indeed, the absence of rational verbal communication soon made the writers realize that whatever they might infer from the patient's speech and behavior must remain speculative.

The present writers first started a group a year ago with three members in the group sessions, a fourth and a fifth one entering shortly thereafter. With one exception, all of the members were on trial visit from a hospital of the Veterans Administration in the vicinity of the office in which the group psychotherapy sessions were held on a semi-weekly basis.

The semi-weekly sessions had the purpose of shortening the intervals of the contact between the members and between the group and the therapists. The principal aim of therapy here was to give support and help to newly released schizophrenic patients from various hospitals. There seemed to be some benefit for the patient just to know that two weekly sessions were available, even though they often were not ready to attend these sessions, since too close contact was, and in some instances still is, frightening to them.

The co-therapist was a social worker, the other therapist a psychiatrist. The idea of a co-therapist was to bring in two separate personalities and to demonstrate their modes of collaboration in the group interaction. This was intended to show not only working together on matters that were agreed, but also to show the patterns of getting along when the therapists might assert themselves in opposition to each other, and still retain a friendly collaboration.

The general aim of the therapy was to assist the patients in their reorientation from the status of an inpatient in a mental institution to that of an outpatient; to assist them in getting over the idea that they were not rejected by or taken care of by society; to get through to them the idea that they were individuals, like any healthy person who has something to offer to society and can be accepted by society. These theses were supported by the topics under discussion during more than 100 sessions that took place up to the time of this writing. Job-seeking, sex and women, sources of affection (in which none of them were successful), emotional involvement, which seemed to be the most difficult problem. At all times it seemed that the therapists constituted the parent figures. these patients were not too dissimilar from groups containing neurotic patients, but dissimilar in the way that the patients considered the sessions not as their "own."

FIRST there was Y., a single 27-year-old Japanese veteran of the Korean conflict. His diagnosis was schizophrenic reaction, chronic,

catatonic type. He comes from a large family with a dominant father and a passive mother. Because of cultural striving, the family encouraged the veteran to come to the United States from Hawaii for an education. While at school he became disturbed over the mental illness of his oldest brother. He was not particulalry successful in school, became dependent upon his siblings and after having served in the armed forces was finally admitted to a VA Hospital at the age of 25. In the hospital he was withdrawn, fearful and isolated from others. Finally, he improved to the point where his siblings took him home. Since this patient had difficulty relating to an individual, he became interested in group therapy. According to him, he had benefited from group therapy in the hospital, but it has been reported that he was not able to speak in the group. Although his family is supporting him, they still think in terms of his working, being unable to accept his dependency.

P. is a 39-year-old single veteran of World War II, diagnosed as having a schizophrenic reaction, paranoid type. Basically he is a dependent, insecure, immature man suffering from feelings of inadequacy. He is the youngest of six children. He was treated for St. Vitus dance between the ages of 10 and 12, revealed having evidences of extreme nervousness at an early age. He completed high school in 1937. He was disturbed at the death of his mother in 1938. After a poor employment history, he entered the armed forces, where he was able to sustain himself for a year. Since the patient's service experience, he has been in and out of hospitals several times. He has been completely dependent upon his father, who dominates him, giving him very little opportunity for self-confidence. He has desired a heterosexual adjustment, but becomes nervous and tense whenever he is with a girl. At the time of his joining the group he lived alone, separated from his father, spending most of his time on the beach. He fears being alone in his apartment, feels safer when out of doors. His greatest pleasure at present is playing handball with an older man. He is consistently seeking some individual upon whom he can completely rely.

S. is the third of four siblings, born when the mother was in her forties. According to the mother, she had had some difficulty with her female organs and was advised not to have any more children after the fourth child was born. All the siblings except the pa-

tient are happily married, with children. No mention was made of the patient's father, except that he was a quiet man. The impression given was that the mother was the dominant member of the family. According to the mother and the patient, all his difficulties were the result of one year of military service. It was her opinion that the hiking and sleeping out of doors were too much for him; he couldn't stand the stress of that kind of living. He had one hospitalization in the Army for one or two months because of his "upset condition." The patient's adjustment to civilian life was poor. He was subsequently hospitalized in a VA hospital in 1946 and stayed there until 1950. According to the mother, the patient was an extrovert before going into the service, but after he returned home he stayed in the house all day and pulled down the shades, refusing to go out. In 1953 he married a woman considerably older than he. Then his condition worsened. The mother was very much against the marriage. Later it was found out that the woman was not legally divorced, whereupon the mother started annulment proceedings. It appears that the mother continuously interfered in the marriage. Like his mother, the patient is an exceedingly eccentric religious fanatic, feeling that he was possessed of evil feelings and spirits that he attempted to exorcise by praying and fasting. His diagnosis was schizophrenic reaction, paranoid type, chronic, manifested by multiple bizarre, somatic and referential delusions.

F. joined the group about seven months after it started and returned to the hospital prior to this writing. His diagnosis, too, was schizophrenia, paranoid type, chronic. Within a month after his attendance he was released from the hospital on trial visit, but within six weeks returned voluntarily to the hospital. He, too, was an eccentric and religious fanatic and the most verbal in his communication and interaction of the group. He was the only one who seemed to benefit from the real acting out. At the time of his release he was living again with his sister and his brother-in-law, unconsciously competing with his brother-in-law for the love of his sister. He had had domineering parents, particularly a rejecting mother, and often spoke of "injustice" done to children, meaning himself. He has had a long series of hospitalizations, the last one being the fifth, and was in the hospital, with minor and short intervals of releases for as long as 14 years.

G., an only child, 36 years old, always has lived with his parents and often spoke in the group of his "papa" and "'mama." He was perhaps the most infantile of the patients in the group. He had served in the war briefly and, for the first four or five months of his participation in the group, was known as the "quiet one." His participation was almost nil. Then, however, he thawed out and soon participated more or less frequently. His favorite subjects were food, beer, real estate and gambling.

ST., 33, was a World War II veteran who had been hospitalized almost continuously since 1951. He had had many types of therapy, including electroshock and insulin therapy consisting of sixty injections. Periodically employed between hospitalizations, he became increasingly disturbed and paranoid. The patient's father, 64, was a second-generation American who had spent most of his time on a farm, was quite passive, and allowed his wife to make most of the decisions. The mother was described as a domineering, cold woman who controlled every member of the family. She apparently resorted to tantrums during which she would throw various articles at whoever happened to be in the vicinity. The patient has one older brother and two older sisters, a younger sister and two younger brothers, a total of seven siblings. The patient was married twice, the first wife having sued him for divorce for unknown reasons; this apparently had hurt him terribly. The wife was an only child. The second wife was six years older than he. Always wanting to have the best, she was "too hard on the pocketbook." She never worked and the patient had to do all the house chores in addition to his job. The couple had one child who in his ten years had known the father only in and out of hospitals. The wife finally started divorce proceedings a year prior to the patient's release on trial visit, as she was afraid that he might kill her. When the patient was released on trial visit, he was given to his guardian, his older sister, who was the manager of an apartment house and gave her brother a janitorial job to look after the apartments. She weighed nearly 350 pounds, was earnestly concerned about her brother and had many conferences with the therapist. She, too, represented "authority" to the patient.

SW, 43, is a separated Army veteran whose diagnosis was anxiety state and impaired hearing. The veteran's mother died in his early youth. His father took no responsibility for him or his siblings, farm-

ing them out to various members of the community. Soon the father gave up all responsibility for the children and they became wards of the state. The veteran has a long history of moving from place to place, never developing any close, warm relationships. Considering his background, it was surprising that he functioned as well as he did. However, his basic insecurity has made it difficult for him to make and sustain material relationships. About a year and a half ago, prior to his trial visit release, he impulsively married a woman he had met in a bar. She turned out to be an alcoholic and he suffered considerable pain in the relationship. The veteran, at the time of joining the group psychotherapy sessions, was seeking a divorce, but the wife was punitive and had managed to get their few associates to "take her side." The veteran is unable to find anyone as a witness for a divorce action. He attempted to find employment, but was never successful.

B., 35, is a veteran with a diagnosis of schizophrenic reaction, paranoid type. He was in veteran hospitals on a number of occasions. He was withdrawn, seclusive, antisocial, generally quiet and cooperative. He had had periods of aggressiveness toward other patients, was confused, lacking in insight and judgment and presented a severe ward management problem because of his frequent attempts to elope. He remained in his condition until about a year prior to his trial visit release, when he began making gradual but steady progress. The mother viewed the patient as being ill mentally but did not know the cause of his illness. She talked openly of the situation in the home, saying that her husband had been a chronic "wino" for fifty years and that she considered him a hopeless case. She was previously divorced, but when the patient was released from the service returned to the father, since she felt she would be unable to cope with the patient alone. She said the patient worshipped his father, mimicking him in everything he did, even to becoming acutely intoxicated for three or four days about twice monthly. The patient started divorce proceedings on the ground of incompatibility and was notified by his attorney that he could sign the final papers. However, he refused to do this. At the time of the patient's joining the sessions he appeared to be well oriented and has since become an active member.

SM is the only Negro patient in the group, with a diagnosis of schizophrenia paranoid type. He is 27 years old and was twice hos-

pitalized. He has been married and has two children who are living in the home of his parents. He is separated from his wife, who, according to the patient, is in a state mental institution. In fact, it is stated that he and his wife met while they were both patients at the state institution. The veteran has never assumed much responsibility for himself and has always been dependent upon his parents for his support. While in school he was a fair student. He became a truant in his early teens and had also become involved with the juvenile authorities and the police.

THE first ten sessions were more or less devoted to orientation to the aim and scope of the meetings. During these sessions members came and went and appeared to be sampling the situation to determine what the sessions might have to offer to them.

The therapists at first explained the reason for the group meetings in simple terms. The individual members were to have an opportunity to share with one another their experiences in life. These experiences might be in the area both of rewarding and difficult experiences. No attempt was made to state any future goals for the group. Already in these early sessions, each member, so far as he was able to participate, brought discussion themes to the group which became their theme.

Y. was able in the first session to suggest timidly that it was difficult to obtain a job. He indicated that he had been seeking employment, but was unsuccessful. Throughout Y's brief contribution it became evident that status was important to him because he could not accept "just any job." Another member, not described above, who attended only two or three times, was threatened by the mention of job-seeking because he spent his time as an ill person at home caring for the children while his wife worked. Incapacity due to illness was his theme. It was evident that this other member caused Y to have anxiety over the group situation and therefore to use his illness defensively.

S. often tried to assume leadership of the group, particularly through his favorite topic, religion. For example, he asked the therapist if life was in the blood, referring to a Biblical statement. While the therapist offered no disagreement, he wondered about the interpretation. When S. pressed the therapist further to agree with him

that life at least arose from the blood, the therapist, as a physician, outlined the bodily functions to show how one organ was dependent upon the other. As S. became aware that his statement was not being denied but rather supplemented, he was able to accept the concept that the value of material learned from the Bible was greatly dependent upon the interpretation of it.

S. once quizzed F. about the latter's hallucinations, imaginations, and delusions, as F. had said he often dreamed he was a locomotive. He also said he sometimes felt like committing suicide. S. and F. felt they had too many guilt feelings. S. became evasive when questioned about his capacity to love and to receive love.

ASIDE from the theme of religion, which F. shared with S., F. brought forward additional themes, such as sex and his difficulty with interpersonal relations, including his relationship to his sister and his brother-in-law. He often wondered whether "we patients should make a better world, although we are only patients." After the first half dozen sessions during F's participation in the group, he was released from the hospital, and from then on he came regularly to the meetings until he asked for readmission to the hospital. While the exact circumstances never became clear, the therapists had indications that his readmission was precipitated by the pressure that F. felt he was under in competing with job situations.

Of all the members of the group, G. was perhaps the most infantile and regressed schizophrenic patient, to whom group therapy apparently was a means to a "legal" and explanatory end: namely to fulfill the "requirements" of his trial visit status from the hospital and to explore with others the extent to which he would feel able to take a job or to leave the dependency situation with his mother. After attending some seventy sessions, he terminated his participation as soon as he had received the official note of his discharge from the hospital. G's major themes, to which he came back time and again, were food, gambling and real estate.

IT WOULD be incorrect to state that there was no response on the part of the group members to the various themes advanced. However, the interaction took other forms than those that can usually be observed in groups of neurotic patients. As the group members be-

came more close knit, there was some group interaction on a limited scale. This was the case between S. and F. on the topic of religion or between S.W., B. and S.M. on jobs and vocational rehabilitation. However, it did not appear to be a true give and take; at best, the awareness of the other members' problems was heightened through the ever-increasing awareness of one's own problems, but a true emotional inter-involvement throughout the group never seemed to take place. We speculate that the various members recognized each other as being relatively unsuccessful and therefore quite limited as resource-friends.

While these sessions continue, although it is hoped that the therapeutic progress will continue, the effectiveness of treatment and its measurement are still uncertain, partly because there is no follow-up. The individual members appeared to be gaining considerable self-assurance in expressing their opinions in the group. At the same time, we were aware that they were much more comfortable in the group. We were uncertain how these changes manifested themselves in the patients' social and job life, except for those patients who found jobs and kept them, and those who reached out more definitely for jobs.

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## The Promise of a Sane World

IT IS NOT TOO MUCH to expect that our children will enjoy in their homes electrical power too cheap to meter, will know of the great periodic famines in the world only as matters of history, will travel effortlessly over seas and under them and through the air with a minimum of danger and at great speeds, and will experience a life span far greater than ours, as disease yields and man comes to understand what causes him to age. This is the forecast for the age of peace.

—*Lewis L. Strauss*

# STIGMA: A SPRINGBOARD TO MENTAL HEALTH

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*A bean while free is better than a feast in prison*
*—Spanish Proverb*

*Everyone sits in a prison of his own ideas* *—Einstein*

ONE may encounter social devaluation or rejection as a result of either personal characteristics or group membership. If the emphasis in stigma is shifted from an interpersonal situation involving the re-education or discipline of others to an intrapersonal situation involving the selecting of an adequate defense mechanism against fear — and anger-motivated impulses, then *stigma becomes a mental health problem*: the criterion of a "good" reply changes, from one of favorably influencing others to one of minimizing a replier's bitter perseveration or self-hatred. In terms of mental health, the usual denial of a stigmatizing remark changes its primary function from that of refuting a bigot's position to that of a Freudian defense mechanism of doubtful hygienic value; a promising alternative to denial as a defense is humor, resulting from a replier's accepting and exaggerating an ascribed trait.

This paper describes an experimental training program for those stigmatized.

## *PROCEDURE*

VOLUNTEER male prison inmates served as subjects. Initial role-playing of an employment interview revealed the use of stereotyped cliches designed to refute any slur upon an ex-convict. After this initial role-playing, each participant was assigned (by flipping a coin) to experimental or control group.

Since any attempt directly to modify a stereotyped response prouces hostile resistance and fixates the response — i.e., its maintenance becomes a primary goal — the trainer modifies the men's methods by examining their objectives. The parolee's obvious objectives, to get a job and remain out of prison, lie outside his control. He is offered a new primary objective, freedom from bitterness over the outcome of a parole or employment interview.

The men role-play the job interview with this new objective, but repeat their earlier stereotypes. To help them inhibit these stereotypes, the trainer suggests that they can obtain their new objective by renouncing the old, i.e., that they avoid getting the job. Laughing, the men relax in the interview, offer new responses and obtain improved reactions from the personnel manager.

At the end of the training program, the trainees were given an anonymous evaluation sheet and tests were then administered to trainees and control subject. These were designed to measure the men's willingness to accept the program and its principles. Specific measures are described in the next section. After testing, the control group was trained.

### *Results*

*1. Evaluation Sheet:* This mimeographed sheet, modified from a course evaluation sheet used at the University of Michigan, contained twelve questions, each followed by a rating scale and space for free comments. Typical questions were: "Has this program helped you with the problem of facing stigma?" "Should a program such as this be a regular part of pre-release?" "Will this training help you in an employment interview? with your family?" etc. The twenty-six evaluation sheets expressed approval of the program. On most the scales, about two-thirds of the men indicated unqualified approval; the remainder were dubious or negative in their reaction.

Their free comments reflected their clear understanding of the goals of the program. Here is a composite of some remarks:

I've learned which problems I should concern myself primarily with. I used to get mad every time I heard the word nigger, but now I think I can take it in stride. I believe it will help those going out on parole even in situations other than employment. It has shown me how not to be bitter. I know now that I stand a better chance in getting a job, because I will feel more comfortable with myself; before, I was too tense. Taught me how to joke about your faults and not to feel bitter. It helped me understand that the people on the outside think just about the same way I do.

2. *Situational Tests:* Three mimeographed episodes tests were used:

(a) During an employment interview the personnel manager tells an applicant: "Well, Mr. Jones, I certainly think you're competent and qualified for this job. But frankly, we've never had the experience of hiring anyone with a prison or jail record, and to tell the truth, I'm not sure we should begin now."

In forty-six protocols belonging to untrained subjects (including pre-tested trainees), the men offered such replies as: "Yes, I made a mistake, which anyone might do, but have learned from my mistake and have paid my debt to society (or, paid for my mistake). Now if you will just give me a chance, say a ninety-day probationary period, I will prove to you that I am competent to do the job. I need the job, having a family at home and being on parole." No man used humor. After training, the men criticized these replies as insincere attempts to conform to correctional philosophy and to "con" a parole board or personnel manager.

Of twenty-nine protocols from trained inmates, fourteen used a humorous reply, tending to exaggerate rather than to refute the justice of the rejection. A composite of these humorous replies follows:

"Well, I can't blame you. I'm not sure you should begin either. Frankly, I wouldn't hire me. After all, I've lived with prison inmates and know what they're like. Everyone of them will hand you a line, tell you he's innocent and never did a wrong thing in his life.

I'm certainly no saint. I'd probably steal your money. I've been away from women so long I'd probably spend most of my time with them, instead of working.

"But I thought your company might be foolish enough to take a crack at hiring someone like myself, so I decided to ask. It's nice to

be out here where women are real, where I can live happy, be free and make love to my wife."

Other than humor, only two replies were used extensively: "I can understand how you feel and would probably feel the same way myself. Still, I need a job."

(b) *Playground Situation* (*ex-inmate's son*). Jimmy has lived in the neighborhood a few weeks and has got along well with the other youngsters his age. One afternoon as he begins to join the boys at baseball, the captain of the team says: "Hey, get out of here, you. You can't be much good. Your dad's a jailbird!" What should Jimmy say?

A composite of the twenty-six replies by untrained men follows: "Yes, my dad made a mistake, which anyone might do. It could happen to your dad, too. But he's learned from his mistake and has paid his debt, and he's a nice guy. After all, some famous men have been jailbirds! I'm not responsible for what my dad did, and this is no reflection on me. It has nothing to do with my being a good ballplayer, I'm as good or better than you, so judge me for myself." Four men suggested that Jimmy ignore the remark; no instance of humor occurred.

Of the nineteen post-tests, eight men used humor, exaggerating the situation with respect to the father, and also tarring the son. "That's right, and he also shot the vice-president of his company downtown yesterday. His parole officer is looking for him now. Not only is he a jailbird, but he is the best jailbird there is. He's slated Public Enemy No. 1. I hope he's stopped beating people up, before he comes out. If you don't let me play on your team, he'll probably gun you down.

"And I'm like my dad, an old deadbeat who can't do anything right. I figure on ending up a jailbird too. Right now this jailbird would like to fly after some hardballs and show you how a jailbird plays baseball."

(c) *Playground Situation (Negro child):* Bobby has just entered a newly integrated school. When he tried to join some of the boys at baseball. one of them shouts at him, "Go away, black boy. We don't let niggers play with us." If Bobby replies, what should he say?

Two of fourteen control (14%) and thirteen experimental (68%) subjects suggested that Bobby might helpfully use humor. No

control subject, and six experimental subjects, offered a specific humorous reply. "Well, this is one nigger can really play ball. Besides, I'm not really a Negro, just been in the sun too long. You jealous because I got a better tan than you? Are you afraid I'm going to melt and get the ball and bat black?"

*3. Personality tests.*

(a) *California Psychological Inventory.* Seventeen items were used, some in a modified form, to test the subject's willingness to accept various statements as true of himself, e.g., "I would lie to get ahead," "I often start things I never finish!" or "I like to be the center of attention." Mean acceptance score of experimental and control subjects was, respectively, 10.8 and 6.7 (statistically significant at the .01 level).

(b) *Who Are You?* The men were to write twenty self-descriptive or self-identifying statements, each beginning with "I am . . . " No control subjects, and eleven of the thirteen experimental subjects, complied with the request for twenty identifications. Of the eleven control subjects, ten scored seven or less.

(c) *Blacky Humor Test.* The men were asked to write a humorous comment in response to each of the eleven Blacky pictures. Twelve of the thirteen experimental subjects, and seven of the fourteen control subjects, scored 10 or 11.

## *Conclusion*

A TEMPORARY, make-believe renunciation of a goal released trainees from dominance by stereotyped responses and permitted them to express alternative replies. Humorously honest in describing their limitations, they expressed and shared a realistic self-picture and were apparently successful both in protecting themselves from bitterness and in increasing their acceptability as employes.

While evaluation sheets suggest that the program was acceptable to the men, a more critical measure of its acceptance and application will be obtained from post-release follow-up. Perhaps the program's acceptability was increased by the trainer's refraining from offering a solution, permitting the men to develop their own replies.

The men were willing to use these replies developed during the

training, with some generalization (a) from an employment interview, to a playground incident; and (b) from stigma based upon ex-inmate status, to stigma based upon ethnic membership. Moreover, trainees became more open and non-defensive, reflected in their greater willingness (a) to accept as true of themselves mildly derogatory statements, and (b) to offer an extensive list of self-descriptive or self-identifying phrases.

This program uses concern about stigma as a basis on which to sell mental health as a primary value. An encounter with stigma may be used as an encounter with self; an employment interview becomes a self-appraisal interview. When one places emotional well-being first, and material considerations second, to be renounced if necessary, then apparently no renunciation is needed; he is likely to gain both.

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## TV, the Child Mind, and Arson

TELEVISION programs that depict how an arsonist sets fires were denounced as "shocking and horrible" by Martin Scott, Chief Fire Marshal of New York, at a forum at Manhattan College attended by 200 police and fire officials. Deploring such detailed descriptions of how a crime is committed, he complained also that death, suffering, sadism and brutality were often treated with callous indifference and that judges, lawyers and law enforcement officers were too often portrayed as dishonest, incompetent and stupid. He showed that 16,000 persons were killed by fires in the country last year. Peter Lynch, Fire Marshal of Nassau County, reported that at least one in every eight fires was set by children. He recommended that such cases be suppressed lest the youngsters go on to set more and bigger fires. Queens County Judge Peter T. Farrell blamed television conditioning for increasing the difficulty of obtaining convictions for arson based on circumstantial evidence.

# A THEORY OF EMPLOYMENT THERAPY FOR THE EX-OFFENDER

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THE Winston Dictionary defines therapy as "division of medical science concerned with the treatment of disease." The American Medical Dictionary refers to it as "the treatment of disease" and Abbot's Ready Reference as "the science of healing." Horace and Ava English defined therapy as "treatment intended to cure or alleviate a disordered condition, so the normal functioning is brought about." These authors then divide therapy into the following classifications, some of the myriad concepts associated with this word being:

Client-centered therapy
Active therapy
Attitude therapy
Dilution therapy
Expressive therapy
Play therapy
Relaxation therapy
Relationship therapy
Speech therapy

Those listed above are but a few of the many specialized approaches to therapy. Therapy, then, seems to be a vague concept con-

cerned with the treatment of the individual but with no real structure or limitation of its own. In the final sense, it is a description of a *process*. For the purposes of this paper, therapy shall be defined as:

An approach or combination of approaches which may provide a process so that the best functioning ability of the individual can be encouraged. Therapy, in this sense, becomes a more pragmatic or socially oriented technique rather than a broad conceptual approach.

One may take issue with such a limited concept of therapy but Slavson, the pioneer in group therapy, describes an incident that classically portrays this conflict of conceptualization. He was asked to "trouble-shoot" in an institution for young delinquents where there had been a series of riots. A number of different professional and custodial staff had been hired, but still the riots continued. After investigation, Slavson noted that the kitchen seemed to be the only area free from stress. The culinary department was supervised by a kindly, white-haired, rotund woman who ladled soup to the boys assisting her. What she essentially "ladled," according to Slavson, was love and affection to which the boys responded. This woman was, in reality, the most effective therapist in the institution.

Therapy, if it is to have any real meaning, should be related to living. It should involve interpersonal relationships, realistic life situations such as employment, education, marriage and, in the final analysis, may provide a balance between the emotional needs and pressures of the "inner life" as contrasted with the reality demands of the "outer life."

ALTHOUGH diverse in their psychiatric theories, Alfred Adler and Harry Stack Sullivan agree on the need for community contact and the dynamism of interpersonal relationships as an essential tool for the development and adjustment of the individual. Adler says: "All failures — neurotics, psychotics, criminals, drunkards, problem children, suicides, perverts and prostitutes — are failures because they are lacking in fellow feeling and social interest. They approach the problems of occupation, friendship and sex without the confidence that they can be solved by cooperation. The meaning they give to life is a private meaning; no one else is benefited by the achievment of their aims and their interest stops short at their own persons. Their goal of success is a goal of mere fictitious personal superiority and

their triumphs have meaning only to themselves."

A partial cause of criminality, therefore, may be found in the inability of the individual to relate to life situations, such as vocations, with any true empathy. They are blocked, Adler points out, by their own defenses so that the inner world and the satisfactions of their private needs become more important than the work itself. To paraphrase Adler, a healthy balance between community adjustment and inner satisfaction would do much toward the adjustment of the individual in an acceptable manner.

Sullivan places even more emphasis on community interaction. Patrick Mullahy summarizes:

> Unless we have devoted a great deal of study and thought to the matter, we tend to think of ourselves as self-contained, physically and mentally isolated beings, looking out upon the world, as it were, from a tower in our own private castle, save perhaps for periodic excursions outside to satisfy physical, emotional and mental needs and desires. And then, further, we tend to assume that these contacts with the outside world are superficial, that our contacts with the world for food and drink, for sex, for conversation, for friendly intercourse, when we are at work or at play, whenever we are actively engaged with people and things, leave us relatively untouched, the same persons as before, our personalities essentially unchanged. Usually it takes a crucial occurrence — the loss of a loved one, removal to a foreign country, a severe illness, intense and prolonged loneliness — to give us a hint that we are more intimately related to the world in which we live than everyday, routine living might lead us to assume.
>
> However, Sullivan holds that the opposite is the case. As long as life lasts, we are, as the psychological jargon has it, "interacting" with our physical and social worlds in such intimate fashion that if, per impossible, we could be absolutely isolated from the physical and mental world in which we have our being, our very life on this earth would be a matter of minutes. Complete isolation is synonymous with death.
>
> We are always interacting with and in the world: we are always undergoing experience. In fact, we are our experience.

What can such a theory mean in a culture where adjustment, acceptance and recognition are often judged in terms of employment? Just as the inner needs of the individual are expressed by the behavior defense, so are the outer needs of the community expressed by its attitudes. These attitudes are indicated by its legal restrictions and

unwritten taboos. Such environment may provide either a permissive and accepting role or an unyielding, restrictive deterrent to the individual who already has had trouble in adjusting. This community ATMOSPHERE is a vital part of the employment therapy concept.

*The Meaning of Employment*

EMPLOYMENT is defined as the state of being occupied, applied or in service or use. People must work. A healthy human organism cannot exist in complete idleness. Rousseau believed in a natural state of being, according to which "noble" savages lived and died. The development of civilization brought with it as its identifying trademark, *Work*. This *Work* soon became an organized, purposeful technique through which man has developed life around him to suit his needs. At this moment, this ability to *work* promises to project mankind beyond his planet and into space.

*Work* is accomplished by the technique of employment. Employment answers the most basic of human needs. It provides food, shelter, clothing and protection for the organism. At the same time, in the present cultural setting, it supplies much deeper satisfactions which are related to many of the motivational aspects of human behavior. Anne Roe, in *The Psychology of Occupation*, attempted to formulate an integrated theory of employment in relation to occupational psychology. This theory was based on previous work done by Maslow in his experiments on motivation and basic need gratifications. Quoting Miss Roe:

> Of particular importance for the psychology of occupations is Maslow's arrangement of basic needs in a hierarch of prepotency. The prepotent needs are more urgent and insistent than the others under equal deprivation, and until the prepotent ones are relatively satisfied, the others do not emerge as consistent motivators of behavior. This hierarchial concept is useful in explaining many aspects of normal and neurotic behavior. These basic needs are:
>
> 1. The psychological needs.
> 2. The safety needs.
> 3. The needs for belongingness and love.
> 4. The need for importance, respect, self-esteem, independence.
> 5. The need for information.
> 6. The need for understanding.
> 7. The need for beauty.
> 8. The need for self-actualization.

> They are arranged in this list in the usual order of potency. A man who is unsatisfied in all his needs will be more urgently, in fact probably totally, concerned with only the first, his need for food and drink. When these are satisfied, he can think of shelter and safety, and then of companionship and so on. It is true that some exceptional persons have achieved such a state by suppression and sublimation, but these are the exceptions, and it is very doubtful that a higher level can be reached by asceticism that can be reached by gratification. This order of potency is usual but not invariable for all persons.

The implications of this theory are meaningful and far-reaching. If most of the primary motivations can be obtained, either totally or in part, through the process of employment, then we have uncovered a process which could be a valuable therapeutic technique. Employment therapy could be combined to form an integrated approach. A partially acceptable definition might be:

*Employment therapy is an approach, or combination of approaches, which provides a process so that the best functioning ability of the individual may be encouraged through the satisfying use of behavior on an occupational level to satisfy motivational needs.* The implication is that the intelligent and supportive use of employment could be a strong factor in both creating and maintaining a drive for adjustment in the present culture. (As the concept of employment therapy is elaborated upon, another definition will be suggested).

The United States Department of Labor has made a scientific analysis of techniques and relationships between workers and their jobs in an effort to utilize manpower in the most efficient manner. Much of this study is listed in the Dictionary of Occupational Titles. World War II and the Korean conflict intensified this study and made the need for scientific evaluation more apparent. The following factors were finally selected as providing the means for evaluation of work potential:

Aptitudes
Interests
Work performed
Physical Capacities
Working Conditions
Training Time
Industry

For the purpose of this concept of employment therapy the factor

of temperament will be considered in greater detail. Certainly the other factors play important roles in proper work adjustment but, from a psychological viewpoint, successful therapy is more easily achieved by a successful application of temperament. The Department of Labor chooses the following definition of temperament, "Those personality qualities which remain fairly constant and reveal a person's intrinsic nature."

## *INPLOYMENT DESIGNATES*

Up to now the discussion of employment has been from within the individual. The meaning of employment and its motivating drives, according to Maslow, have all been based on an inner orientation. Temperament factors also are designated by the Department of Labor as structures stemming from an inner direction. Although this emphasis is but one part of the total employment therapy picture, such factors, relating to the employment situation which stem from the satisfactions of inner pressures, tensions or motivational needs shall be termed *Inployment Designates*. These designates stem from within the individual and establish "movement" toward work. This "movement" differs in symbolic and realistic content according to the individual, thus explaining the variety of inner needs that employment satisfies.

The Bureau of Employment Security has a designated code that sums up the inployment designates. *SKAPATI* refers to the body of skills which the job applicant is seeking to market. The designates referred to in this code are:

1. Skills — Use of knowledge to execute or perform effectively and readily.
2. Knowledge — Background, adequacy of information, "know-how."
3. Ability — Proficiency in any kind of work or activity.
4. Physical Status — The physical capacity to do the job.
5. Aptitudes — Potential or undeveloped abilities.
6. Traits — Personal characteristics, which primarily include appearance, attitude and manner.
7. Interests — Choice of vocation, job satisfaction through desire to do that job.

These seven factors express those inner needs which the individual brings to the labor market. As any of these designates change, the effect on the work field varies inversely so that the job must ful-

fill as much of the *SKAPATI* as possible in order to be satisfying and therapeutically useful to the applicant.

An example of interaction between the work field and the inployment designates is illustrated by the following case history:

An 18-year-old probationer who had been arrested for driving a car without a license was referred for employment. He was a son of a vagrant, alcoholic father and a promiscuous mother whose marriage had produced four children. The boy had held a job in a brush factory. He finally quit because the mucilage, made from a part of horse carcass, caused him to lose his appetite and become ill at the sight of food. Employment testing and counseling revealed average intelligence, little work skills but high finger and mechanical dexterities and a strong, gregarious interest in people. He had finished high school with average grades but, at the time of counseling, was too emotionally blocked by his arrest to display any real interest in further education. Employment was finally obtained in a neighborhood chain automotive parts store. He was trained as a part-time salesman and installer of parts. This placement answered a number of his needs. Mechanical aptitudes, gregariousness and the realistic and legal demands of his probation were supported by this work area.

## *THE EX-OFFENDER*

Since this theory of employment therapy is being developed for a particular group, designated as ex-offenders, some discussion of this population should be made. A common definition of the offender is "one who transgresses laws or sins." Innumerable books have been written about the criminal and the newspapers are filled with lurid descriptions of all types of anti-social activities. Criminality is the great leveler, since it has never been a respecter of station, status or person. Recent years have seen the introduction of Congressional investigation committees understand this problem more clearly. American crime has been called the biggest of all businesses, representing a multi-billion-dollar drain on the national resources and calling for our best thought in curbing it. More than 2,500,000 of our total population are added yearly to the list of those who will some day be classed as ex-offenders. Even granting that a large part of this group are recidivists, it is difficult to visualize the vastness of this problem.

# BOOK REVIEWS

**Drugs and the Mind**

*Robert S. de Ropp. Grove Press, Inc., New York.*

THE mind does not exist in a vacuum. It is associated with the chemistry of the brain and this chemistry underlies all our manifestations. Neither thought nor emotion can occur without some chemical change. The cruelty of the tyrant, the compassion of the saint, the ardor of lovers, the hatred of foes all are based on chemical processes."

Thus expanding R. W. Gerard's dictum that "there can be no twisted thought without a twisted molecule," Dr. deRopp sets the theme for his fascinating disquisition on the epochal flowering of psychopharmacology. An erudite biochemist with a flair for journalistic popularization, he is an ideal guide to the labyrinthine byways of psychoneurology, chemistry and social therapy that have been merged in the last few years to produce a new concept of the tractability of mental disorder. For the layman and for the unspecialized practitioner here is a valuable handbook for what may prove to be the outstanding scientific development of our time.

The kernel of the book is a concise summary of the properties and uses of the sedatives, ataraxics and analeptics (and the hallucinogens as well) that have so crucially reshaped the direction of psychotherapy. But the usefulness of this section is enhanced by its being integrated in the whole story of drugs and the mind. Dr. deRopp expertly and entertainingly guides the reader through the history of man's attempts to find euphoria, nepenthe or mere equilibrium by means of crude or ethical pharmacology. In his survey of addictions he rightly includes alcohol, coffee, tea and tobacco along with marihuana, morphine, opium and the others. (Incidentally, his ideas on the control of habit-forming drugs vary considerably from the prevailing official ones.) Then Dr. deRopp makes clear the basic psychiatric problem of reducing the anxieties, fears and tensions that increasingly afflict man, and shows how the recent developments and discoveries of pharmacology have added new dimensions of hope to the quest for a direct answer to the challenge of behavioral pathology

and misfunction. In his discussion of experiments with mescalin, for example, he touches upon the "M" factor in schizophrenia. His question as to whether the "metabolic error" that seems to occur in the body of the schizophrenic may not be a result of the production of some substance with properties similar to those of mescalin serves as an epitome of the crucial problem now being worked out by psychopharmacology.

An introduction by Dr. Nathan S. Kline points up the importance of this progress in the treatment of mental illness and its burgeoning promise of achieving "something more than mere surcease of sorrow."

First published in 1957, *Drugs and the Mind* now is made available to a wider public in the notable Evergreen paperback series. The swift pace of psychopharmacology is indicated in a postscript noting more recent additions to the list of chemical therapeutics. It is significant that even this addendum, dated last October, is already outpaced by the introduction of additional chemotherapeutic agents since that time.

**A Short History of Psychiatry**

*Erwin H. Ackerknecht, Hafner Publishing Company, New York and London*

TRANSLATED from the German, this little book presents with a scope unaffected by its brevity the engrossing story of psychiatry. Starting with the ethnological rudiments of science and proceeding through the Greco-Roman and Renaissance eras, Dr. Ackerknecht traces with expert grasp the century-by-century evolution of the aspects of medicine concerned with the diagnosis and treatment of aberration. A German-born scholar who spent sixteen years in the United States and is now Professor of the History of Medicine at Zurich University, he endows his narrative with cosmopoliton insight and leavens it with considered judgments on many of the focal personalities and developments in the profession. For example, his strictures on the psychiatric applications of Pavlov's work and the perspective with which he places Freud among his compeers reflect a measure of informed appraisal that is more useful than detached objectivity would have been. In short, it is an illuminating book for the general reader and a handy reference source for the professional.

### Psychiatry in General Practice

*Jacques A. Weijel, M.D., Elsevier Publishing Company, New York and Amsterdam.*

DR. Weijel, an institutional psychiatrist in Amsterdam, has gone to great pains to provide a guidebook for the general practitioner who would profit from a modicum of psychiatric equipment. Though his milieu and outlook are European, his material and suggestions are appropriate for universal application. With precise thoroughness reflecting his professional acumen, he clarifies the position and uses of psychiatry and goes on to discuss the situations in which physicians will find a psychotherapeutic outlook useful. One tool he offers is a psychosocial questionnaire that may be employed to put the patient's problems in a setting that will reveal their nonsomatic facets. His predominant emphasis is on the essential value of diagnosis.

"Modern tranquilizers are easy to prescribe and they seem to effect cures, but the danger lies in their masking the real cause," he cautions. "If we want to make psychiatry available for general practice, we must first raise the level of diagnosis; this will be possible only if we regard general practice as a specific field whose exploration calls for special tools and methods. We can then approach the patient not just as a case but also as a human being."

### Family and Class Dynamics in Mental Illness

*Jerome K. Myers, Ph.D., and Bertram H. Roberts, M.D., John Wiley & Sons, Inc., New York.*

THIS is the second research report in the New Haven study of social class and mental illness. Dr. Myers, a sociologist, and the late Dr. Roberts, a psychiatrist, both at Yale, carried out the project as a sequel to Dr. August B. Hollinghead's provocative study in the same field. Largely statistical, it considers a cross-section of cases of mental illness in the New Haven community from the standpoint of class factors. The cases were grouped according to economic and vocational status and conclusions drawn from the incidence of mental difficulty in those settings. The conclusions, offered as hypotheses for further research, are that a comprehensive understanding of psychiatric illnesses needs to include social class variables. "Organic, intra-

psychic and interpersonal factors alone are not sufficient to explain the development of mental illness," the authors assert. They found that the class component was clearer in the symptomatology of neurotics than of schizophrenics, although it was manifest in the content of the latter's illnesses as well. They found an especially significant difference not only in the paths to psychiatric illnesses but in symptom patterns between the 21% of the community's population in the white-collar category and the 18% consisting of skilled factory workers and unskilled laborers.

**Pornography and the Law**

*Eberhard and Phyllis Kronhausen, Ballantine Books, Inc., New York*

THE receding frontier of literary censorship continues to narrow the dividing line between the writer's license and the remaining taboos on pornography. In the last decade or two novelists have appropriated with impunity the liberty to present almost any human situation, however intimate. As one book after another carries this frankness a little further, the censor's battle has become a harried rear-guard action to defend what remains of propriety against the ultimate abandonment of all restraint. In the debate that has accompanied this progression of spade-calling, a moot distinction has emerged between what is called erotic realism, which is sanctioned, and hard-core obscenity, which remains illicit.

Dr. Kronhausen and his wife, San Francisco psychologists, have been active in the movement to justify realistic writing, having served as expert witnesses in court cases involving specific works. Out of this experience and their attendant researches they have produced this survey of the material and ideas involved in the dispute. Its central purpose is to define erotic realism and thus provide a practical yardstick for permissibility.

"In pornography (hard core obscenity) the main purpose is to stimulate erotic response in the reader," the Kronhausens submit. "In erotic realism truthful description of the basic realities of life, as the individual experiences it, is of the essence, even if such portrayals (whether by reason of humor, or revulsion, or any other cause) have a decidedly anti-erotic effect. But by the same token, if while writ-

ing realistically on the subject of sex, the author succeeds in moving his reader, this too is erotic realism, and it is axiomatic that the reader should respond erotically to such writing, just as the sensitive reader will respond, perhaps by actually crying, to a sad scene, or by laughing when laughter is evoked."

The Kronhausens make some sensible comments on the potentially therapeutic effects of some realistic writing, though the extent to which they would implement this principle is controversial. They offer an interesting synthesis of some old and recent examples of erotic realism, ranging from Boccaccio and Casanova to Henry Miller and *Lady Chatterley's Lover*, as well as a free-wheeling anthology of excerpts of familiar pornography, from Aretino to latter-day bookleggers' items. Not all readers of their compendium will agree with their classifications.

### The Mind of the Murderer

*Manfred S. Guttmacher, M.D. Farrar, Straus & Cudahy, Inc., New York*

PUBLICATION of the Isaac Ray Lectures delivered by Dr. Guttmacher at the University of Minnesota in 1958 serves many useful purposes. It presents a synthesis of his observation and analysis of various types of murderers. It supplements these data with a survey and discussion of the many onerous forensic problems involved in medical testimony in criminal and civil cases in the doctor-patient relationship. It distills the lessons drawn from Dr. Guttmacher's psychiatric practice and his administration of the Supreme Court clinic in Baltimore. And it conveys a wholesome impression of the broad serviceabiltiy of psychotherapeutic endeavor.

The general and the professional reader will find the book fascinating as well as instructive. Dr. Guttmacher's conversational style imparts a broad range of information and insight with laconic simplicity. His collection of illustrative cases sparkles with drama, humor and pathos that prove again life's ascendancy over fiction. His categorization of murderers illustrates his scope: putatively normal, sociopathic, alcoholic, avenging, schizophrenic, temporarily psychotic, homosexual, passive-aggressive, sadistic, homicide-suicide and gyno-

cide. In each classification he presents apt cases and brings out the psychodynamics involved. His comments and conclusions point to the responsibility of parents and the community in predisposing children to violent crime, the possibility of preventing such murders by controlling and treating persons of psychopathic tendency, and the relative rarity of homicidal outbursts without some prior observable indication.

Of 175 cases included in Dr. Guttmacher's study, 105 were found to have been clearly nonpsychotic at the time of the murder, 53 were psychotic and 17 were seriously abnormal persons in whom a psychosis at the time of the crime could not be clearly established. In 10% of the cases it was difficult to reach a decision as to the seriousness and significance of the mental disorder at the time of the act. A third of the psychotic group but only 3% of the nonpsychotic group had prior psychiatric institutionalization. A fifth of the psychotic group and two-fifths of the nonpsychotic had prior criminal convictions. More than a third of the psychotic group were partly or wholly amnesic for the crime.

On the captious side, one must observe that the constricted lecture form in which Dr. Guttmacher's chapters were cast commits them to a sparseness of content that limits their analytical effect. Although he advocates routine psychiatric examination of all blatant offenders, he gives scant attention to pathological and traumatic factors. Indeed, his emphasis on the psychogenetics of frustration, as contradistinct from "hidden neurotic complexes," would seem to differ from other clinicians' growing recognition of the importance of constitutional defect in the determination of violence. Also, it appears that his selected cases reflect regional characteristics presumably varying from general averages.

**Freudianism and the Literary Mind**

*Frederick L. Hoffman, Grove Press, Inc., New York*

WHAT would literature — and the rest of life, for that matter — be like if the cultural current symbolized by the name of Freud had not appeared? Even though it is manifest that the movement he

spearheaded would have been inevitable even if there had been no Freud, its impact on culture and therapeutic concepts has in fact occurred under his generic label. Professor Hoffman of the University of Wisconsin set out to appraise this epochal wave in the mid-forties. His retrospective review of the literary currents of the half century is now republished in expanded form as an Evergreen paperback. This detailed examination of the Freudian theory, its spread and influence, is a record of lasting value. Mainly objective, it sets down with scholarly thoroughness what happened to the literary world as a result of recognition of the irrational factor in man's deportment. It is especially interesting in its suggestion that something akin to Freudianism was already fermenting in the literary mind before the movement matured. For example, to what extent did Freud influence Joyce, an did not D. H. Lawrence anticipate him? Lawrence's partial rejection of Freud and the cross-currents found in the work of Kafka and Thomas Mann are among other absorbing points in the study. Hoffman, incidentally, gives due credit to Freud for insisting upon the tentative character of his work and for deprecating the presumptions of some of his disciples and the schisms of Jung and others. He concludes:

"Freud's meticulously correct choreography of the unconscious maintains the advantage of its discretion. Language in all of its scope of meanings and half-meanings and super-meanings may fit into his remarkable analysis of the psychic economy. The ambiguities of our intelligence, alternating between residence in the id and regretful acceptance of the ego. While we may find types of identity with the past, we are not what we were some thousands of years ago; however tempting it is to suggest archetypal identifications, our psychic peculiarities are in the end available only to the sober testimony of systematic investigation. To say otherwise is to ignore both the dilemma and the specific intelligence of our times."

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# WORLD OF SOCIAL THERAPY

*A miscellany of ideas, observations, comment and other signals of progress in the purview of the social sciences.*

**Catastrophes**—Accidents in which five or more persons lost their lives killed more than 1,400 people in 1959, according to the Metropolitan Life Insurance Company. This was 150 fewer than in 1958 and the lowest since 1941. Four of the five major catastrophes were civil air crashes, the fifth the Yellowstone earthquake. Motor vehicles were responsible for about two-fifths of the lives lost in catastrophes.

**Deaths**—The 1,647,886 deaths recorded in 1958 (9.5 per thousand, compared with 9.6 in 1957) were attributed to heart disease, 637,246; cancer, 254,426; strokes and other vascular lesions, 190,758; automobiles, 36,981; other accidents, 53,623.

**Drug**—Trials in more than a dozen institutions have produced encouraging reports on a new synthetic psychotherapeutic drug for the treatment of anxiety states, the journal Diseases of the Nervous System reports. The drug, marketed as Librium, is said to be unrelated to any other in use and to be chemically and clinically different from any psychotherapeutic product.

**Eating**—Secretary of Agriculture Ezra Taft Benson advises teen-agers to eat well "for the sheer physical energy which is a prime asset for success in life." Lack of knowledge about proper eating is a factor in the weakening of family life and the rise of juvenile delinquency, he believes: "The traditional family meal time is a value we cannot afford to lose."

**Epidemic**—The wane of tuberculosis represents the end of an epidemic that lasted nearly 300 years, according to a hypothesis presented by Dr. H. D. Chalke, health officer of Camberwell, London. He recalls that the disease has afflicted Western peoples since the seventeenth century, that it burned freely for 200 years and began to die down in the nineteenth century, before the era of chemotherapy and control programs. "Man seems to be coming to terms with tuberculosis," he concludes.

**Fat**—Teen-agers' fat-packed diet of ice cream, hamburgers, milkshakes, bacon and mayonnaise sandwiches and sugared drinks is preparing them for coronary occlusion, Dr. Stanley M. Garn suggests in a report to the White House Conference on Children and Youth. He points to a striking resemblance to the laboratory diet used to produce obesity in rats and notes that urban and suburban trends are rapidly diminishing youngsters' outlets for caloric expenditure.

**Health Costs**—The average American family is paying 42% more for personal health services than it did in 1953, a Health Information Foundation survey shows. Doctor bills took 34% of the health dollar, hospitals 23%, drugs and medication 20%, dental services 15% and other goods and services, such as eyeglasses and special nurses, 8%. One-third of the families spent more than $300 in a year, with 16% of these spending more than $500. Women spent an average of $111, men $77.

**Insurance**—The number of Americans subscribing to hospital insurance has nearly doubled in ten years, from 66,000,000 in 1950 to 125,000,000, Health Insurance Institute figures show. Progress also was marked in medical insurance, surgical expense coverage, loss of income and major medical expense insurance.

**Jails**—Correction Commissioner Anna M. Kross of New York City has proposed that the state establish a new penal institution to relieve the growing crowding of the city's jails. Citing a prison census of 8,447 compared with a normal capacity of 6,600, she contended that a third of the city's prisoners rightfully belong in state institutions.

**Killer**—Cancer is responsible for more deaths of American children than any other cause except accidents, Therapeutic Notes reports. The figure for deaths from cancer, including leukemia, between the ages 1 and 14 is 12%. A significant number of malignant tumors are present at or before birth. More than half of the childhood cases of leukemia occur before the age of 5.

**Literacy**—The nation's illiteracy rate fell to a new low of just over 2% last year, the Census Bureau reports. The relatively small number of illiterates now is concentrated mostly in the older age groups. Non-whites' progress is especially striking; illiteracy among them dropped from 80% in 1870 to 8% in 1959. About half the adult population has finished high school, double the level of 1940.

**Mental Cases**—The number of resident patients in public mental hospitals dropped in 1959 for the fourth consecutive year. There were 542,721 patients in 277 hospitals at the end of the year, 2,142 fewer than at the end of 1958, the National Institute of Mental Health reported.

**News**—Need for prompter, fuller and simpler means of reporting news of medicine and research has inspired plans for a daily newspaper, The Medical Tribune, to be published by the American Research and Development Corporation, Boston. The paper, to be distributed free to physicians, will start as a weekly with plans for daily publication next year.

**Pressures**—Dr. James B. Conant, former president of Harvard, has protested "almost vicious" overemphasis on competitive athletics in high schools and extreme academic pressures for the sake of getting pupils into college. In a report on his study of junior high schools he warned against a tendency to look for "educational miracles" to replace hard work and the efforts of good teachers.

**Prison**—On the site of an abandoned prison in Galway, Ireland, a new $1,800,000 Cathedral of Our Lady and St. Nicholas is rising. Bishop Michael Browne has been raising funds in the United States for the project, begun when the county decided the prison was no longer needed.

**Reading**—At least a fourth of the students seeking college admission in 1970 will be rejected because they cannot read or write on a college level, Paul B. Diederich of the Educational Testing Service, Princeton, predicts. Increases in high school enrollment by then will make it impossible for a teacher to require more than four English papers a year from a student under present procedures, he finds. He proposes the supplementary help of readers and technicians to administer English study.

**Social Illness**—Congress' refusal to appropriate funds for the study of social illnesses as well as mental ones has been protested by Arthur S. Flemming, Secretary of Health, Education and Welfare. He pointed to the need, as exemplified in juvenile delinquency, to determine why some people remain dependent upon public assistance. "We really don't know the causes of juvenile delinquency," Mr. Flemming said. "Why shouldn't we be willing to invest a few hundred thousand to get at the cause of social illnesses that are costing us billions each year?"

**Speech**—An immediate need for 20,000 trained speech pathologists to help rehabilitate persons with speech defects was put before a Congressional committee on special education by Prof. Jack Matthews of the University of Pittsburgh.

**Teens**—The number of teen-age fathers in the U.S. rose from 40,000 in 1940 to 106,000 in 1957, or 165%, the Metropolitan Life Insurance Company records. The only exception to a general rise in birth rates was in families where the husband is 55 or older.

**Textbooks**—Dr. Albert Alexander, textbook analyst for the New York City Board of Education, charges that "a gray flannel cover" on the prevailing American history textbook symbolizes a safe comformity that robs it of inspiration and vitality. He declares the texts are artificially balanced to please partisians on every side in each controversy, are "critical of neither the past nor the present" and are devoid of any opinion or interpretation.

## AMONG THE AUTHORS

GROVES B. SMITH, M.D. president of the Medical Correctional Association, has been consultant to the Illinois Department of Public Safety since 1943. He supervises the Psychiatric Division of the State Penitentiary at Menard, Ill., and serves in similar capacity at the Beverly Farm Foundation at Godfrey. Born and educated in Illinois, he received his M.D. at Columbia University and psychiatric training at Bellevue Hospital prior to medical service in the Army in World War I. Later, while on the staff of the Washington University Medical School, he was an attending specialist in the Veterans Bureau. He took part in organizing the first mental hygiene clinic in connection with the courts of St. Louis. In 1923 he supervised part of the New York Prison Survey. From 1923 to 1928 he was associate neuro-psychiatrist at the Henry Ford Hospital, Detroit. After that he returned to Illinois as superintendent of a school for mentally handicapped children, meanwhile continuing as consultant to courts and social agencies in examining persons with mental deviations. For ten years he was consultant to the Justice Department in the evaluation of veterans' mental status.

ERNEST HARMS, Ph.D., editor of the journal *The Nervous Child,* the *Child Psychiatry Journal* and a handbook on child guidance, has been director of child guidance clinics in New York for the last ten years. Former director of the Internationale Voelkerpsychologische Institut, he teaches at the New School of Social Research and has conducted comprehensive research in social and abnormal psychology, part of it for the Government. An early student of psychiatry, he has been associated during his long international career with Freud, Janet, McDougall, Morton Prince, Adolf Meyer, Adler, Smith Ely Jelliffe and Ira S. Wile. He received his Ph.D. in psychology from Wuerzburg University in 1919.

ALBERT EGLASH, Ph.D., is a member of the faculty of Washington College, Chestertown, Md. He formerly taught at Wisconsin State College, LaCrosse. A native of Los Angeles, he majored in psychology at the University of California there and took his Ph.D. at the University of Michigan. After broad professional experience in the Graduate School at Ann Arbor, he served in Detroit as a member of the Mayor's Rehabilitation Committee on Skid Row Problems and of the Detroit Youth Commission.

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